Does Clinical Supervision Impact Supervisee Competence in Clinical Practice: A Systematic Review

Student and Supervisor Experiences of the Systemic Practice Scale (SPS): A Discourse Analysis

Submitted by Dr Claire Hannah Parker, to the University of Exeter

as a thesis for the degree of Doctor of Clinical Psychology, May 2019

I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

LITERATURE REVIEW

Does Clinical Supervision Impact Supervisee Competence in Clinical Practice? A Systematic Review

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Abstract

Clinical supervision is a key factor in the professional development and competence of the supervisee. The recent shift towards competence-based practice has highlighted a need to understand the relationship between supervision and supervisee competence further. A systematic review following PRISMA-P guidelines aimed to summarise and synthesise the literature across five databases exploring the impact of supervision on supervisee competence and the factors that may contribute to effective supervision. Eleven papers met the search criteria and were included within the review. A narrative synthesis of the findings provided some evidence of a positive relationship between supervision and supervisee competence with feedback and the supervisory relationship shown as important factors. The implications for future research and practice are discussed.

Keywords: competence, supervision, supervisee, systematic review

Introduction

Clinical supervision is viewed as an essential part of clinical training and clinical governance across health professions (Roth & Pilling, 2007; Watkins, 2011). There are numerous definitions of the function of supervision in clinical practice. These broadly address the professional development and competence of the supervisee through risk and case management in order for safe and effective practice (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; O'Donovan, Halford & Walters, 2011). Although the definition of competence varies depending on the context, it is broadly understood to encompass the development of knowledge, skills and attitudes (Kaslow et al., 2004).

Supervision is viewed as a valued part of clinical training (Scott, Pachana & Solranoff, 2011; Wilson, Davies & Weatherhead, 2016). Scott et al. (2011) conducted a survey of clinical psychology programme directors and postgraduate students in Australia reporting supervision to be rated by both as essential in the student's training and development. The survey found self-report of perceived competence was the most frequently used method to assess the trainees' clinical work whilst in training. In addition, research has reported the role of supervision in contributing to improved supervisee emotional wellbeing, therapeutic awareness and confidence in ability (Bernard & Goodyear, 2014; De Stefano et al., 2007; Vallance, 2004).

The evaluation of supervisee competence has been recognised to occur primarily through verbal discussion between the supervisor and supervisee (Falender & Shafranske, 2004; Tweed, Graber & Wang, 2010). A need for effective ways to measure a supervisee's competence has been acknowledged in the recent

development of the University College London competence frameworks (UCL, 2019). These frameworks set out specific competences for individuals to develop knowledge and skills relevant to specific models of therapy and clinical populations (UCL, 2019). In addition, more structured psychometric measures such as, the Cognitive Therapy Scale- Revised (CTS-R, Blackburn et al., 2001), the Clinical Skills Assessment Rating (CSA-R, Tweed et al., 2010), and the recent Systemic Practice Scale (SPS, Butler et al., 2018) are all used to assess competence within the context of cognitive behaviour therapy (CBT), clinical psychology and systemic practice respectively.

The purpose of assessing an individual's competence is to provide helpful, meaningful and constructive feedback for the individual to reflect on their clinical skills and highlight possible areas of development. Clinical supervision is argued to aid the development of competencies in clinical practice, however the specific aspects of the supervisory process associated with this are still not well understood (Falender & Shafrenske, 2004; Milne, 2007; Stolenberg, 2005).

Wilson et al. (2016) completed a qualitative meta-synthesis of trainee therapists' experiences of supervision during training. They described supervision as an opportunity for learning and reiterated the importance of the supervisory relationship in facilitating this process. Heckman-Stone's (2004) review of the literature indicated feedback and evaluation to be effective in producing change in supervisees' practice, facilitated through a supportive supervisory relationship. Research supports the importance of the supervisory relationship in the success of supervision (Ladany, Ellis & Friedlander, 1999; Kilminster & Jolly, 2000). Kilminster and Jolly's (2000) review of supervision in clinical practice settings found the

supervisory relationship and clear feedback to be the most important factors for the supervisees in their development.

Gonsalvez, Hamid, Savage and Livni (2017) suggest the effectiveness of supervision is evaluated at two levels, “first-order supervisee levels (e.g. extent to which supervisee competence is enhanced) and at second-order, flow on effects on client outcomes (individual/family/organization) deriving from both supervisor and supervisee competence” (p. 96). Previous reviews in the area have focused on the role of supervision, competence and client outcome (Milne & James, 2000; Watkins, 2011; Wheeler & Richards, 2007). Milne & James (2000) found some support for a positive effect of supervision and supervisee competence in CBT and client outcome. The effect was noted through supervisory methods that included feedback, modeling and idiosyncratic instruction, however methodological issues with both the review procedure and the studies included meant the findings were weak and inferences from these findings were limited. Wheeler & Richards (2007) conducted a systematic review of literature examining the impact of clinical supervision on counsellors’ and psychotherapists’ practice and their clients. The quality of the evidence varied but supervision was regarded to have a positive impact on the supervisee’s development.

More recently Alfonsson, Parling, Spannargard, Anderson & Lundgren (2018) conducted a systematic review that explored the effects of clinical supervision on supervisees’ competences and clinical outcomes in CBT. They found limited research supporting the positive effects of clinical supervision on therapist's competence in CBT. The review highlighted several methodological limitations including poor study designs and a need for better conceptualization and measures of supervision features. Specific formats of supervision such as video monitoring

however showed promising findings at improving the psychotherapist's competence and patient outcomes but the research in this area is limited (Alfonsson et al., 2018). Although considerable research has been conducted on models of supervision theory (Falender & Shafranske, 2004) there appear to be gaps in rigorous systematic reviews of the area of supervision and supervisee competence. It is hoped if supervisee competence improved inevitably this would have positive clinical implications for clients (Roth & Pilling, 2007).

Rationale

The importance of supervision in clinical training is well established (Falander & Shafranske, 2004; O'Donovan, Halford & Walters, 2011). There has been a shift towards competence-based practice and the need to measure competence of clinicians in clinical practice has been highlighted (Butler et al., 2018; Roth & Pilling, 2007). Some have argued the need for high quality empirical evidence that examines the relationship specifically between supervision and supervisee competence as a specific outcome (Bambling et al., 2006; O'Donovan et al., 2011).

Previous research has evidenced the importance of supervision in supervisee development (Heckman-Stone, 2004; Kilminster & Jolly, 2000; Milne & James, 2000; Wilson et al., 2016; Wheeler & Richards, 2007). However there appears to be limited research which focuses specifically on the relationship between supervision and supervisee competence; highlighted as a recommended area of future research in the meta-synthesis of trainee therapists' experiences of supervision (Wilson et al., 2016) and in the recent systematic review conducted by Alfonsson et al. (2018). Alfonsson and colleagues examined the effects of clinical supervision on supervisee competence in CBT and patient outcomes, finding some evidence to support the role

of supervision in competence development whilst also highlighting the need for further empirical literature.

The current review aims to extend the work of Alfonsson et al. (2018) which focused solely on the model of CBT. The current review has no restrictions on the therapeutic model of practice and specifically focuses on the outcome of supervisee competence and not the impact of supervision on client outcomes, which has previously been well researched (Milne & James, 2000; Watkins, 2011; Wheeler & Richards, 2007).

The definition of both concepts of supervision and competence can vary depending on the therapeutic model or client group which can mean they are difficult to define and measure. Therefore, for the purposes of the present review a broad definition of clinical supervision was used, to include individual and group supervision, face-to-face or other means of communication, e.g. telephone. There were no restrictions on the model of supervision used. As there are few standard measures for evaluating psychotherapy supervision, like Alfonsson et al. (2018) a broad range of outcome measures were accepted to include the attitudes and experiences of supervisees and their competence development. Similarly, the definition of competence for the present review was also broad, to include any reference to the supervisees perceived (self-reported) or observed competence within their clinical work (e.g. measured through a psychometric scale).

In order to capture the development of competence in supervisees, participants included are those deemed to be trainees in the therapeutic model of interest however, the review did not exclude supervisees who were also qualified therapists in other therapeutic models.

Aim of Systematic Review

The aim is to provide a systematic review of the literature that explores the relationship between clinical supervision and supervisee perceived and/or observed competence in clinical practice. The review focused on the impact supervision had on supervisee competence not evaluated through patient outcome.

The review aims to contribute to and extend reviews in the field of clinical supervision as described previously by broadening the inclusion of the therapeutic approach and type of supervision used, with specific focus on the outcome of supervisee competence. This to the best of our knowledge is the first paper to systematically review this area in such a way.

Literature review questions.

Does clinical supervision impact supervisee perceived and/or observed competence in clinical practice?

What factors contribute to effective supervision in the development of supervisee competence?

Method

The review was conducted following guidelines proposed by The Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols (PRISMA-P, Moher et al., 2015). Studies looking at the relationship between supervision and supervisee perceived and/or observed competence were examined in this review.

Eligibility Criteria

The PICOS (Population, Intervention, Comparison, Outcome, Study type) framework was used to screen for the eligibility of study characteristics (Table 1) as recommended by PRISMA-P (Moher et al., 2015). Table 1 summarises the inclusion and exclusion of eligible studies.

Table 1.

PICOS Framework for the Inclusion and Exclusion of Studies within the Review

	Inclusion criteria	Exclusion criteria
Population	Trainee therapists, trainee practitioners including psychology post graduates. Therapists training in a particular model. No specific level of training/competence specified. Not gender specific No date restriction	Non-clinicians (e.g. those whose only role is non-clinical) Trainee role is not within the mental health profession.
Intervention	Clinical supervision of trainee therapists (to include all modes of supervision; group, individual, video, online)	No reference to clinical supervision on trainee therapist competence
Comparison	N/A	N/A
Outcome	Trainee therapist experience of	Outcomes unrelated to

	supervision on perceived or observed competence. Supervisory factors that impact trainee therapists perceived or observed competence	trainee therapists' experience of clinical supervision and perceived or observed competence.
Study type	Peer-reviewed articles Primary research Qualitative research articles Quantitative research articles	Editorials Opinions or discussion pieces Books/book chapters/policy documents/web pages/book reviews Articles that have not been published in English or where a translation cannot be accessed Non-peer reviewed articles.

Search Strategy and Information Sources

The search strategy was created in consultation with researchers and clinicians and contained keywords that were combined with Boolean operators to optimize the search strategy (Higgins & Green, 2011).

The following search terms were used to search across the databases.

1. (Trainee therap*) OR (Trainee Psycholog*) OR (Trainee Practitioner*) OR (Psychology practitioner*) AND
2. (Supervis*) OR (Clinical Supervis*) AND
3. (Competence*) OR (professional competence*) OR (Experience*) OR (Perception*)

Databases were searched from inception to October 2018 these included: PsycINFO, Medline, CINAHL, Applied Social Science Index and Abstracts (ASSIA) and Web of Science. Amendments were made to the search strategy depending on the database. For example, proximity operators such as “adj2” and “near” were used within PsycINFO and ASSIA to increase the sensitivity of the search strategy (Appendix A).

As recommended by National Institute for Health and Care Excellence (NICE) guidelines (2012) the included publications’ references lists were hand-searched to ensure no relevant papers had been missed. Journals screened included *The Clinical Supervisor*, *Clinical Psychology and Psychotherapy* and *The Journal of Clinical Psychology*. Grey literature was not considered within this review due to the time restrictions of the study. All citations were stored on the electronic bibliographic database EndNote.

Screening and Data Extraction

Titles and abstracts were screened based on the inclusion and exclusion criteria (Table 1) and any duplicates were removed. Figure 1 displays the screening process. At this stage of screening, six papers were randomly selected and double-rated blind by a second rater to ensure reliability for the inclusion and exclusion criteria. Disagreements were resolved through discussion. One paper was discussed and inclusion criteria were clarified therefore 100% inter-rater reliability was achieved.

Data were extracted from the full texts and summarised (Table 2).

Appraising the Quality and Risk of Bias of Selected Studies

As recommended by the Centre for Reviews and Dissemination (CRD, 2009) eligible texts were reviewed in full and assessed for quality and risk of bias (n=11; Table 2). Three of the included studies used mixed-method designs. In these instances, the quality tool was selected depending on the predominant research design of the study.

The Quality Assessment tool for Quantitative studies was used to assess quality and risk of bias of quantitative articles (n=9; QATQS; Appendix B; Effective Public Health Practice Project (EPHPP), Thomas, Ciliska, Dobbins & Micucci, 2004). Each article was rated for quality across six components: A) selection bias, B) study design, C) confounders, D) blinding, E) data collection methods, and F) withdrawals and dropouts. Each component was scored as strong, moderate or weak, with an overall rating given. At this stage two of the included quantitative studies were double-rated blind for quality. Inter-rater reliability was 100%.

Qualitative articles were assessed using the Critical Appraisal Skills Programme (CASP) assessment tool (n=2; CASP, 2013, see Appendix C). The CASP comprises of 10 questions to address the rigour and relevance of the research where a score from 0 – 3 was assigned depending on the presence of the criteria being assessed. The scoring was completed by CP and 1 qualitative study was double-rated blind, inter-rater reliability was 100%.

Studies were not excluded based on the quality of the assessment but contributed to the overall discussion of evidence.

Method of Data Synthesis

In line with the synthesis of data presented in Alfonsson et al.'s review (2018), it was expected that the included studies' results will not be comparable due to differing outcome measures and analyses and therefore a meta-analysis not applicable. A narrative synthesis of the findings will be presented and where appropriate, effect sizes, using Cohen's *d*.

Results

Results of the Search

From the database and journal searches, 779 potentially relevant records were identified (Figure 1). After removal of duplicates (n=136), the titles and abstracts of 643 records were screened, of which 609 records were removed. The most frequent reasons for exclusion after full-text screening are outlined in Figure 1.

Full text articles of the remaining 34 records were assessed for eligibility, of which eleven articles met inclusion criteria and were included within the review (Table 2). The study numbers included in Table 2 are used throughout the results and discussion sections to correspond to the study.

The included studies were heterogeneous in aims and quality. All included articles explored the impact of supervision processes on supervisee competence in a therapeutic context. Studies were published between 2004 and 2017, suggesting a relatively recent body of research. The following section will first describe and compare the study characteristics before considering the quality of the included studies. The main findings of the review will then be presented.

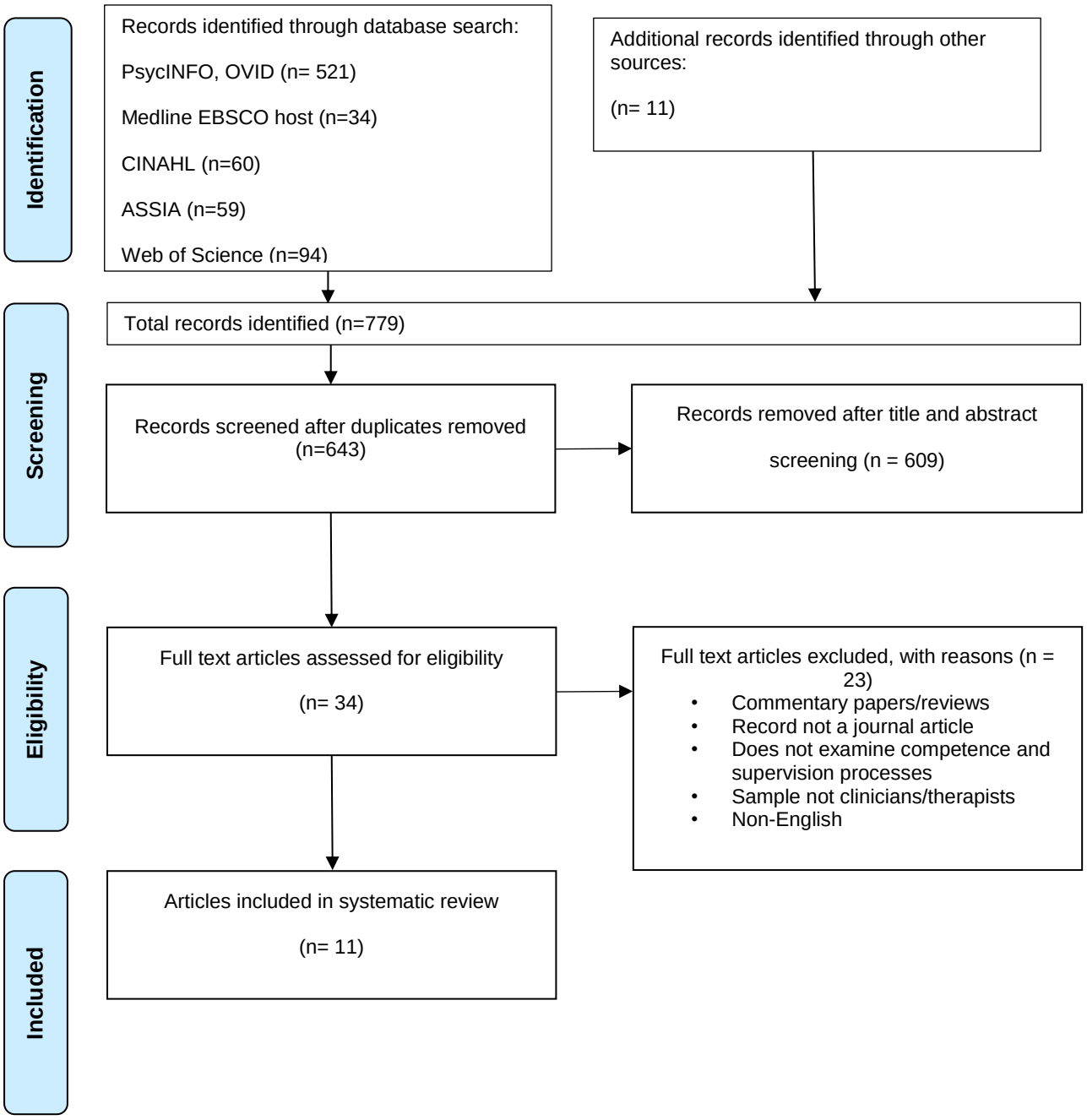

Figure 1. PRISMA flow diagram

Study Characteristics

The characteristics of the eleven included studies are summarised in Table 2. A brief summary of the differences in the study characteristics are presented in the following section.

The majority of studies used quantitative designs (1, 2, 5, 7, 8, 9, 10, 11), with the remaining utilising mixed-methods (3, 6) or qualitative (4). The studies were broadly based in the UK or US (1, 2, 3, 4, 5, 6, 8, 10), with one based in Germany (11), one in Sweden (7) and one in Russia and Ukraine (9). Sample sizes were relatively small across the majority of included studies ranging from 7 to 73, although two studies had larger sample sizes of around 300 participants (6, 7).

Although all studies reported on the therapist experience of supervision on perceived or observed competence, this was not always the primary outcome of the study.

There were variations in the type of therapists that participated in the studies, although as previously discussed all were trainees or novices within the therapeutic model being explored. A number were mental health trainees including clinical psychologists and psychotherapists (1, 4, 6, 7, 9, 11). However, it was unclear as to whether these therapists had other clinical qualifications. Other intervention approaches included: CBT (2, 8), counselling (10) and motivational interviewing (MI) (5). One study included medical doctors who were on rotation training in dialectical behavior therapy (DBT, 3).

Studies varied in the type of supervision reported and how supervision was measured (e.g. group conditions of supervision or self-reported measures of supervision). From the eleven included studies five studies evaluated the impact of group supervision on observed competence (1, 3, 5, 7, 11). Of these five studies, one study (7) described general group supervision whereas the other four studies utilised a randomized control design (RCT) and compared different conditions of supervision including: supervision as usual (SAU), supervision plus active learning

techniques (SUP+), bug in the eye (BITE), delayed video-based (DVB), internet-based therapy with supervision (IBT-S) and MI.

Five studies used self-reported measures to explore frequency, effectiveness and the perceived impact and importance of supervision on therapist observed competence (2, 3, 6, 8, 10). One study explored the experience of supervision through clinical interviews with participants (4).

The measurement of competence (perceived or observed) varied across the studies. Some measured specific observed competence in relation to a clinical model (CBT, DBT or MI) (1, 2, 3, 5, 8, 9, 11) and others explored therapist perceived competence more generally (4, 6, 7, 10).

Five studies (1, 2, 8, 9, 11) measured observed competence using a specific standardised scale for CBT, (CTS; Blackburn et al., 2001; CBTCOMP-YP; Lau & Weisz, 2012). Both measures utilised supervisor ratings of therapists' CBT competence often completed on videoed sessions. DBT and MI competence were examined using specific measures relevant to the model for two studies (3, 5).

Three studies relied on supervisee self-reported perceived competence (6, 7, 10). Two studies used self-evaluation scales (7, 10), whilst one used a survey to examine supervisee competence specifically designed for the study (6). One study used no specific measure of competence however, this was a theme presented in the qualitative findings (4).

Quality of Studies Included

Each of the eleven studies were evaluated using the QATQS (n=9) or CASP (n=2) depending on the predominant research design (Table 2). The quality of the

included quantitative studies varied with the QATQS scores ranging from Weak (n=4), Moderate (n=4) to Strong (n=1; Table 3, Appendix B). The two studies rated using CASP criteria (2013), were rated as 6 and 7 out of 10 (Table 4; Appendix C). Both studies reported aims and methods well, however both studies failed to discuss the researcher's role within the research.

Five of the included studies (1, 3, 5, 9, 11) used an RCT design which under the QATQS rating system is regarded as a strong methodological approach. Although the studies used this design the sample sizes were relatively small, and few commented on the confounders that were adjusted. It was unclear based on the reported statistics of studies whether the power was sufficient to accurately detect difference. Therefore, the inferences that could be drawn from these studies were limited.

Selection bias within the samples was another area that varied across the studies. Randomisation processes were well reported. However, the samples that most studies drew from were of participants motivated to participate, self-selecting into the study. This could have implications on how competence was perceived and whether those who perceived themselves as less competent would not have chosen to participate in the studies. This was not clear from the included studies.

Table 2. Summary of articles included for analysis, ordered alphabetically by author

No	Reference and Country	Design/ Method	Sample	Competence Measures	Supervision (e.g. type, frequency, model)	Analysis	Main Findings	Evaluation	QATQS/ CASP category and global score
1	Bearman, Schneiderman & Zoloth, 2017. United States	Randomised analogue experimental design to control for the effect of supervision on cognitive restructuring fidelity, CBT expertise and global CBT competence.	Mental health trainees enrolled in clinical psychology and school-clinical psychology doctoral programs, n =40 (SAU n=19, SUP+ n=21). 36 females and 4 males (*M* age (years) = 25, SD = 2.26)	Observed competence measured using the CBTCOMP-YD (Lau & Weisz, 2012)	Group supervision (SAU or SUP+) – one hour a week for three weeks following a 3-hour workshop.	Paired sample T-tests to compare effects of training pre/post to randomisation. Behavioural rehearsal coding, mixed effects repeated measure models for each outcome (e.g. competence).	Both conditions significantly improved from pre to post training across cognitive restructuring fidelity, CBT expertise and global CBT competence. Participants showed increased knowledge of CBT and global competence in the SUP+ group, pre to post supervision workshop (*β = 1.04, t = 5.87 <p 0.001, d = 0.64*). The type of supervision received differentially impacted therapist behaviour e.g. the	**Strengths** Examined causal relation between supervision and therapist outcome. Held client complexity as a constant to systematically assess therapist fidelity. Use of a control group. Standardised measure of CBT competence. **Limitations** Small sample, motivated to participate, possible bias. No follow-up period.	A- Moderate B- Strong C- Strong D- Moderate E- Strong F- Strong **Global rating- Strong**

							inclusion of role-play, corrective feedback increased CBT expertise and global competence.	Generalisability to training and supervision for therapists.	
2	Brosan, Reynolds & Moore, 2006. United Kingdom	Within participants correlational design	Therapists completing post-qualifying training in CBT (n =24). 17 females and 7 males (*M* age (years) = 38, SD 6.5).	Observed competence measured with Cognitive Therapy Scale (CTS), tapes rated by experienced CBT therapists.	Self-reported frequency of supervision (weekly, once every two weeks, once a month, less than once a month or not at all).	Group differences in rated competence compared to training, experience, and profession and supervision frequency using Mann-Whitney Test. Chi-square and fishers exact test explored categorical associations, Pearson correlations in whole sample.	Examined the relationship of therapist factors to ratings of cognitive therapy measured using the CTS. The only factor significantly related to competence was the level of training (*M* = 20.5, SD 4.6, U = 10.0, p<0.001). Number of years of experience, frequency of supervision and accreditation unrelated to ratings of competence.	**Strengths** Standardised measure of CBT competence. **Limitations** Small sample size. Poor response rate (51%). Correlational design. Self-reported supervision frequency, no measure of supervision. Self-selected sample.	A- Weak B- Weak C- Weak D- Weak E- Strong F- n/a **Global rating- Weak**

3	Carmel et al., 2016. United States	Mixed-methods Randomised to Supervision as usual (SAU) or BITE with additional telephone interviews.	Trainee psychotherapists (n=8, n = 4 SAU, n = 4 BITE).	DBT theory and skills exam, 50 items completed at the end of the DBT training rotation. DBT case formulation graded by a DBT therapist not blind to treatment condition, completed 5 months into training.	Group BITE supervision or individual SAU. Supervision effectiveness measured using the Manchester Clinical Supervision Scale – 26 (MCSS-26, Winstanley & White, 2011) and supervisor feedback.	Independent samples Mann-Whitney U test compared scores. Qualitative content analysis of semi-structured interviews.	Supports the use of technological approaches like BITE in supervision to increase competence in DBT. Found those in the BITE group had significantly higher scores on case formulation (n=4, *Mdn* =3.6, *U* = .00, p0.02, r =0.83). Also reported higher scores on DBT exam in BITE condition. Themes identified from semi-structured interviews: Issues with the structure of BITE supervision, time management within supervision, helpful process of feedback.	**Strengths** Use of BITE technology. Randomisation process – although limitations noted below with sample. **Limitations** Small sample, no demographic information provided. Small sample for significance testing. No measure of adherence to DBT group differences. No control for other factors which may impact supervision effectiveness.	A- Moderate B- Strong C- Weak D- Moderate E- Strong F- Strong **Global rating- Moderate**

4	Johnston & Milne, 2012. United Kingdom	Qualitative – grounded theory methodology interviews	Trainee clinical psychologists (n= 7), all female (*M* age (years) = 26.71, SD 2.06).	No specific measure of competence used.	Interviews explored participants' experiences of supervision (models of supervision varied dependent on the placement included: CBT, systemic, cognitive analytic and 'eclectic' supervision.	Grounded theory. Used NVIVO (QSR, 2012) to organise data.	The receipt of supervision was experienced developmentally involving the progression of competence and awareness. Core processes were thought to interact enabling learning. The authors discuss the findings in the context of a model of CBT supervision.	**Strengths** Findings contribute to the emergent model of CBT supervision. Presents experiences of supervision. **Limitations** Supervisees from one course. No specific model of supervision tested, trainees were not selected on experience of CBT supervision.	**CASP 6/10**
5	Martino et al., 2016. United States	Randomised controlled trial, competency-based supervision Motivational interviewing (MI) was compared to SAU.	MI clinicians (n= 66). 52 females, 14 males (*M* age (years) = 41.3, SD 13.2).	Observed competence and adherence of MI measured though coding of video sessions using the Independent Tape Rater Scale (ITRS).	Supervision conditions, MIA: STEP, clinicians' videos were rated, and feedback given using the ITRS. SAU included usual practice; checklist	Linear regression models were completed for outcomes including competence.	Demonstrated that supervision post training increased MI competence in both MIA: STEP and SAU conditions. Those in MIA: STEP showed significantly higher increased competence in MI strategies	**Strengths** Retention post trial Supervision as usual group **Limitations** Biased group of those included in the study - motivated	A- Strong B- Strong C- Weak D- Strong E- Strong F- Strong **Global rating- Moderate**

					completed to summarise sessions.		compared to SAU (*M* = 3.99 (SD 0.68) vs. *M* = 3.85 (0.66)).		
6	Nel, Pezzolesi & Stott, 2012. United Kingdom	Mixed methods-retrospective survey design.	Trainee clinical Psychologists (n=357). 252 females, 105 males (*M* age (years) = 41, SD 12).	No specific measure of competence used. Self-reported perceived competence reported.	Self-reported perceived importance of supervision on practice measured using a survey developed by the authors.	First stage: frequency analysis of responses differences compared chi-square and fisher's exact. Second stage: qualitative thematic analysis from two open-ended questions	Live clinical supervision was rated as important and useful by 93% significantly associated with years qualified. Thematic analysis highlighted clinicians perceived they learned best through observation and supervision to develop competency. Discussed the importance of the supervisory relationship for learning to occur.	**Strengths** Large sample size **Limitations** Self-reported, perceived competence and the importance of supervision. Retrospective responses.	**CASP 7/10**

7	Ogren & Jonsson, 2004 Sweden	Cohort - Between participants correlational design	Students part of a five-year academic training for psychology (n=323).	Change in therapeutic skill (perceived competence) measured using the Self-evaluation scale (SES, Olsson, 1996)	Skill assessed following group supervision. Group supervision once a week for 2 hours.	Factor analyses, Cronbach's alpha. T-tests and one-way ANOVA comparing group differences.	Showed significant increases in skill and positive changes of skill after supervision, supervisees perceiving self as more skilful after supervision (N= 76, *M* = 0.14 SD 0.39, p<0.001). Group supervision contributing to greater skill increase.	**Strengths** Standardised measure of perceived competence. Factor analysis of type of skill important in supervision. **Limitations** No demographic data of sample. Skill presumed to represent competence. Self-reported perceived skill (competence) increase. No psychometric properties of MSES provided.	A- Weak B- Weak C- Weak D- Weak E- Weak F- Weak **Global rating- Weak**

8	Rakovshik & McManus, 2013. United Kingdom	Mixed method survey design of pre and post training CBT competence ratings.	Trainees (n= 73). 46 females, 27 males (*M* age (years) = 39.59, SD 8.38).	Observed competence measured using the CTS.	Self-reported the perceived impact of supervision on competence, through course impact questionnaire	Paired t-tests compared trainee ratings.	CTS mean item scores increased from 2.95 (SD = 0.64) to 3.83 (SD = 0.69), with a significant difference (t_{72} = 8.31, p<0.001). Supervision perceived to have the strongest impact on competence and on trainees' preparation for practice. Trainees rated supervision significantly more highly compared to clinical instruction (*M* = 4.49 (SD 0.75): vs. 3.74 (SD 0.69); t_{72} = 8.34, p<0.001).	**Strengths** Standardised measure of CBT competence. **Limitations** Self-reported. Retrospective design, representative population queried. CBT model of supervision not specified.	A- Strong B- Moderate C- Weak D- Weak E- Strong F- n/a **Global rating- Weak**

9	Rakovshik et al., 2016. Russia and Ukraine	Randomised control trial. Randomised to IBT-CW, IBT-S and DT (who did not receive the training until after all data had been collected).	Practicing therapists training in CBT (n=61), 43 females, 18 males.	Observed competence measured using the CTS.	Skype supervision was given to the IBT-S group consisting of three 30-minute individual monthly sessions.	Linear random effect models considered multiple measurements Sensitivity analysis was conducted.	CTS mean item scores significantly increased over time (baseline: 1.1 (95% CI = 0.6, 1.5, p<0.001) to time 2: 1.2 (95% CI = 0.8, 1.6, p<0.001). IBT-S showing significantly higher CBT competence from baseline ((M = 2.33 (SD 0.9)) post-training ((*M* = 3.56 (SD 0.9)), than IBT-CW (M = 2.87 (SD 1.0)) or DT (*M* = 2.17 (SD 1.2)).	**Strengths** Standardised measure of CBT competence Design **Limitations** No follow up period Supervisory bias in rating competence due to non-blindness of primary rater.	A- Moderate B- Strong C- Weak D- Moderate E- Strong F- n/a **Global rating-Moderate**
10	Steward, Breland & Neil, 2001. United States	Within participants correlational design	Counselling trainees (n=36). 32 females, 5 males (one participant missing from overall n presented in paper).	Perceived competence self-reported using Evaluation of Counsellor Behaviours – Long Form (Bernard, 1981)	Perceived impact of supervisor style on trainee competence measured through the Supervisory Styles Inventory (SSI, Friedlander & Ward, 1984).	Pearson correlations and multiple regression	The perception of supervisor's style impacted self-evaluation of competence (r= .59, p< 0.001). Supported the importance of the support-challenge aspect of supervision.	**Strengths** Standardised measures used. **Limitations** Self-reported Inconsistent reporting of sample size Multi-collinearity.	A- Moderate B- Moderate C- Weak D- Weak E- Strong F- n/a **Global rating-Weak**

11	Weck et al., 2016. Germany	Randomised control trial. Randomised to DVB or BITE.	Therapists in psychotherapy training (n=23). 20 females, 3 males (*M* age (years) = 29.30, SD 3.34).	Observed competence measured using CTS.	Supervision groups DVB or BITE. In both conditions' therapists received six supervisory sessions during the treatment of the therapists' patient.	Latent growth curve models were specified for repeated ratings of therapeutic alliance and competence. ANCOVA's on the group differences between the BITE and DVB conditions.	Therapeutic alliance and therapeutic competence were stronger among those who had BITE supervision compared to DVB for the CTS (Cohen's d = 0.39-0.66, p=00.9).	**Strengths** Standardised measure of CBT competence. Randomised sample. **Limitations** Difference in therapeutic competence and therapeutic alliance were present at first therapy session between conditions. Self-report of therapeutic alliance and competence.	A- Moderate B- Strong C- Weak D- Strong E- Strong F- Strong **Global rating- Moderate**

*Note: QATQS = Quality Assessment tool for Quantitative studies (Thomas et al., 2004): A= Selection Bias, B = Study Design, C = Confounders, D = Blinding, E = Data Collection Method, F = Withdrawals and Dropouts. CASP = Critical Appraisal Skills Programme (CASP, 2013), CBTCOMP-YD = Cognitive Behavioural Therapy Competence Observational Measure of Performance with Youth Depression (Lau & Weisz, 2012), SAU = Supervision as usual, SUP+ = Supervision plus active learning techniques, MIA: STEP = Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency, BITE = Bug in the Eye, DVB = Delayed Video-Based, DT = delayed training controls, IBT-CW = Internet based therapy with consultation worksheet, IBT-S = Internet based therapy with supervision.

Main Findings and Implications

The following section presents the main findings of the review. The studies are grouped to firstly consider the impact of supervision on supervisee competence (observed vs. perceived) and to consider how supervision was measured.

Secondly the findings consider factors identified in the studies that were perceived to contribute to effective supervision. Studies were grouped by the process of feedback and the role of the supervisory relationship.

The impact of clinical supervision on supervisee competence.

Competence (observed vs. perceived). The outcome of competence was measured using standardised measures of observed competence, self-report of perceived competence or presented as a theme discussed within an interview. All studies except one (2) showed a positive association between supervision and increased therapist competence both perceived and observed (1, 3, 4, 5, 6, 7, 8, 9, 10, 11). One strongly rated study (1) reported effect sizes that were moderate; d =0.64, showing increased competence for participants in the SUP+ condition. The additional elements of scaffolding and experiential learning strategies included in the SUP+ compared to the SAU condition appear to significantly improve competence outcomes. The effect size was calculated for the purpose of the review for one study (5) and showed a similar moderate effect, d = 0.49. It was however not possible to calculate the effect size of other studies due to the statistics reported.

One study reported no positive association between supervision and increased therapist competence evidencing the level of training to be the only factor significantly related to increased competence (2). The quality of the study was weak due to the small sample size and correlational design. Other factors such as

motivation of the supervisee and pre-existing competence in CBT were queried as contributing to this finding however due to the study design could not be tested.

In the five studies that measured observed competence, the CTS or a measure of CBT competence was used (1, 2, 8, 9, 11). A notable strength of these studies was the use of an established standardised measure of CBT competence. This potentially reduced the bias and increased reliability amongst assessing competence of the supervisees and generalizability of the findings.

The five studies that used perceived competence utilised supervisee self-report measures (6, 7, 10), case formulation (3) or it was discussed as part of the study interview (4). Self-report can lead to potential bias of data however; it has been argued that evaluation of supervisee competence primarily occurs through verbal discussion which would be based on perceived self-reported competence and therefore may be a fairer reflection (Tweed et al., 2010).

How supervision was measured. A significant limitation of the included studies was the variation in how they measured and reported on supervision. It was not clear from all the included studies the frequency and intensity of most of the supervision provided or the model of supervision used. This was not always a primary focus of the study, for example one study (2) was interested in the relationship of supervisee factors (e.g. experience, profession) and competence ratings and examined the frequency of supervision and competence but found no significant relationship.

Six studies relied on self-reported information from the supervisee regarding the experience of supervision (2, 3, 4, 6, 8, 10). These studies were interested in the perceived importance of supervision and perceived impact of supervision on

competence. Three of the studies relied on feedback from the supervisee collected through surveys specific to the study (2, 4, 6) or participant interviews (4).

Two studies used psychometric measures to examine elements of supervision (3, 10). Study 3 used the MCSS-26 (Winstanley & White, 2011), a well validated measure of the effectiveness of supervision across three domains which includes formative development of clinical knowledge and skill of the supervisee. Study 10 assessed supervisory styles using the Supervisory Styles Inventory (SSI, Friedlander & Ward, 1984) a validated measure where trainees rate various supervisory styles including attractiveness and interpersonal sensitivity.

In the RCT designs the type of supervision used in the studies varied to include supervision as usual vs. a specific supervision type (e.g. BITE, DVB). Studies that examined the impact of a specific type of supervision compared to SAU reported significantly improved CBT competence overall for both groups, with an increased effect for the intervention groups (3, 11). A strength of the RCT design was the ability to explore differences across supervision type, e.g. one study (11) reported stronger therapeutic competence amongst supervisees who had received BITE supervision compared with DVB.

What factors contribute to effective supervision in the development of trainee therapists' competence?

The process of feedback. A number of core processes particularly related to feedback were identified in the studies as contributing to the development of therapist competence during supervision (1, 3, 4, 6, 8, 11).

Three studies supported the positive impact of feedback on CBT competence (1, 8, 3). A highly rated study (1) identified these core processes as *active learning*

strategies including: skill modeling, role play and corrective feedback which had significant impact on participants' global CBT competence. Across the three supervision meetings participants had shown incremental improvements in their global CBT competence if supervision had included these processes (1). Similarly, study 6 reported direct feedback during supervision to have a positive impact on CBT competence, yet the retrospective design of the study could impact the recall of participants. A moderately rated study (11) evidenced increased CBT competence for those in the BITE supervision intervention. The purpose of BITE supervision is to enable immediate feedback to be given live to the supervisee whilst in a session. Live supervision feedback is thought to be more useful than delayed supervisory input (Rousmaniere & Frederickson, 2013). This supervision intervention was also used in another moderately rated study which found increased DBT competence for those in the BITE group compared to participants receiving SAU (3).

The Socratic approach to information exchange and feedback was noted as an important factor within the qualitative study (4), in which the supervisee in collaboration with the supervisor was able to ensure the learning process was developmentally appropriate and motivating in developing the supervisee's competence. Interestingly, the participant's level of confidence was associated with the feedback received in supervision; which the authors had found to be of importance in the development of competence (4). Similarly the qualitative findings of study 6 reported the value of constructive feedback on supervisee performance. However, these were two optional open-ended questions of the study and were not completed by all participants therefore it is not possible to know if there was a bias to those who valued feedback to respond to these questions.

Supervisory relationship. Three studies noted the role of the supervisory relationship or alliance as an important factor in how supervisee competence developed (4, 6, 10). Study 6 reported the importance participants placed on the quality of the relationship with supervisors for learning to occur. However, these findings were restricted to thematic analysis of two open-ended questions and therefore findings were tentative.

Similarly, others have highlighted how a strong supervisory alliance enables disclosure, mutuality and support with the relationship (Palomo, Beinart & Cooper, 2010). The importance of the supervisory alliance was a theme within study 4. Supervisees shared how the perceived strength of their supervisory alliance would impact how *open* and *honest* they were about their needs. The authors (4) discussed how the "*emotional climate engendered within the supervisory alliance had a strong impact on what was received and reflected upon"* (p.14) which contributed to their overall development and competence.

Study 10 noted a correlation between perceived attractiveness of the supervisor (attractiveness defined as friendly, flexible, supportive, open, positive, and warm) with supervisee accuracy of self-evaluation. This was a poorly rated study particularly due to potential multi-collinearity between variables.

Discussion

The purpose of this review was to evaluate the literature that reported on the impact of clinical supervision on supervisee competence, and the factors that contribute to effective supervision in this process. A comprehensive search identified eleven studies which met the inclusion criteria. Consistent with previous research the included studies suggest an overall positive association between supervision and supervisee perceived and observed competence. Although both feedback and the supervisory relationship were factors found to contribute to the process of competence development within supervision (Heckman-Stone, 2004; Kilminster & Jolly, 2000); the process of feedback was better evidenced in the current review. Both these main findings are tentative due to methodological limitations and complexities identified within this area of research which will be discussed.

The included studies varied in the measures assessing competence and the type of supervision which made it difficult to draw conclusive comparisons across the studies. The findings however provided some evidence of the positive impact of clinical supervision on supervisee competence. Of particular interest in this review was the impact of increased supervisee competence in those groups where an additional element was included within the supervision condition (e.g. BITE, DVB, and SUP_{+}).

The use of BITE supervision for example, increased overall DBT (3) and CBT (11) competence in the supervisees. BITE has been argued to be advantageous to supervisees learning in the moment (Rousmaniere & Frederickson, 2013). Methodological limitations in these studies meant the generalisability of these findings is limited. The sample size of study 3 was particularly small which may have

led to chance findings. Study 11 showed baseline differences between supervisee CBT competences to be present at the first therapy session and due to the small sample size the study was unable to explore this further in the analysis.

Study 1 found significant differences between therapists' CBT and global competence, pre and post training, in the two supervision groups however this was based on a small sample of motivated participants and there was no follow-up period. This was a general theme across the studies and no longitudinal studies were included within the review or follow-up periods which could inform the longer-term impact of supervisory processes on competence development. As many of the studies did not explicitly report on confounders, it was unclear if supervisee factors such as previous experience and supervisor competence impacted on the supervision processes.

The review evidenced feedback as a potential contributory factor within supervision on the development of supervisee competence, however further research is needed to establish the role and type of feedback that is key. Similarly the supervisory relationship was identified as an important factor. Heckman-Stone's (2004) review of existing literature indicated feedback and evaluation to be effective in producing change in supervisees, facilitated through a supportive supervisory relationship which was a consistent finding within the present review.

The current review supports and extends the work of Alfonsson and colleagues (2018) who explored the effects of supervision on CBT competence. The present review included a broader inclusion criterion of therapeutic approach and no restrictions on how competence was measured. Three of the papers (3, 9, 11) were included in the current review. However two papers Bambling (2006), and Tanner,

Gray & Haaga (2012) were excluded. Bambling (2006) was excluded from the current review as the focus of competence development was discussed in relation to treatment outcome and Tanner et al., (2012) focused on the effects of co-therapy on trainee effectiveness measured by symptom distress in patients.

Strengths and Limitations

One of the main strengths of conducting a systematic review is the methodology used to identify, select and review the relevant literature, in order to minimise bias. Specific search terms were carefully selected to address the research questions, although the search terms were amended in an iterative process, two of the included papers were identified through hand-searches (3, 9). Neither paper referenced competence within the abstract, title or keywords. Both papers included the term “training” however when this was added to the search terms the number of studies increased considerably and through discussion with a specialist librarian it was deemed appropriate to omit the term. The present review included no grey literature due to time constraints which may have impacted publication bias of the included studies, future reviews could be improved further by inclusion of unpublished literature.

A further strength of the review was the inclusion of both perceived and observed competence. For clarity, within the current review, distinctions were made between observed competence if the competence had been measured using a standardised measure and/or approach. The inclusion of perceived competence meant the review was not limited to therapy models that have used standardised measures of competence and included self-report of supervisees, as this is common practice in clinical training and practice (Tweed et al., 2010). Many of the studies

included examined observed competence in relation to a specific model or intervention. Some therapeutic approaches include structured competence scales e.g. CBT, CAT, systemic practice. Interestingly studies included in the review only used structured CBT measures and no other model specific measure was used, which is a limitation of this review.

The review took a broad approach to exploring the impact of supervision on supervisee competence extending previous reviews conducted (Alfonsson, 2018). However, similar to the review conducted by Alfonsson et al. (2018) methodological limitations meant the generalisability of the findings was limited. The quality of the studies varied. The QATQS measure used to assess quantitative studies favoured RCTs which meant a number of studies were scored lower due to the design but also those rated higher due to an RCT may be misleading to the overall quality of the study.

The process of developing competence is complex and is likely to be impacted by a number of supervisory and individual factors that were not explored in the current review. The studies included in this review were unable to provide the mechanisms of change related to competence development which would be beneficial to explore further. Factors related to supervision styles e.g. frequency, type, intensity were also not always provided and therefore comparisons across studies was not possible. Criticisms have been made around the methods of measurement of supervisee competence, the bias that may exist within supervisory relationships and how this would impact the way competence is measured (Tweed, et al., 2010).

Implications for Future Research and Practice

Although it is accepted that supervision is an important aspect of clinical practice, in line with the conclusions of Alfonsson et al. (2018) the present review suggests a more empirical approach to understanding the components and possible mechanisms that contribute to improved clinical competence for supervisees is needed. Feedback for example was highlighted as a contributory factor within this review; however further research to understand this relationship is needed e.g. clarity on how feedback is provided within supervision.

The majority of studies measured CBT competence which could reflect the increased interest and funding for CBT trials with the development of IAPT and the need for outcome measures both for the client and clinician. Sharpless & Barber (2009) highlight the challenges for other disciplines such as Clinical Psychology, which is characterised by multiple competing paradigms. They argued the way some competence measures are used may be a limitation when considering the broader competence of a clinician.

One qualitative study was included within the current review and presented some of the supervisee's perception of supervision where competence was discussed (4). However, this was not a specific focus of the research and further exploration between competence development and the supervisory process could be explored, as supported by Wilson et al.'s review (2016). In addition, it would be interesting to untangle further the potential barriers of using competence scales in supervision and whether they are helpful as an adjunct to the more informal evaluative conversations that take place (Tweed et al., 2010; Butler et al., 2018).

Although the review considered how supervision was measured it did not explicitly focus on the competence of the supervisor to deliver supervision. In most studies the role of the supervisor was discussed yet not explored further. Falender & Shafranske (2004), highlighted this as an area of professional practice which has largely been neglected although there have been some recent developments such as the UCL competence framework for supervision. This is an important area for future research as it potentially impacts on service development (i.e. accessibility of supervisors and their training and continued professional development) as well as patient outcomes (UCL, 2019).

Conclusion

The importance of clinical supervision is widely accepted and with a shift towards competence-based practice there is a need to understand the relationship between supervision and supervisee competence development. The current review systematically explored the relationship between clinical supervision and supervisee perceived and/or observed competence in clinical practice. The review extended a previous review conducted by Alfonsson et al. (2018) by broadening the inclusion of the therapeutic approach and focusing specifically on the role of supervision. The current review has demonstrated some evidence of a positive relationship between supervision and supervisee competence however the review raises a number of limitations with the studies and questions how best to measure this relationship in future studies.

References

Alfonsson, S., Parling, T., Spannargard, A., Andersson, G., & Lundgren, T. (2018). The effects of clinical supervision on supervisees and patients in cognitive behavioural therapy: a systematic review. *Cognitive Behaviour Therapy*, *47*, 206-228.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research*, *16*, 317–331.

Bearman, S. K., Schneiderman, R., I., & Zoloth, E. (2017). Building an evidence base for effective supervision practices: An analogue experiment of supervision to increase EBT fidelity. *Administration and Policy in Mental Health*, *44*, 293-307.

Bernard, J. M. (1981). Inservice training for clinical supervisors. *Professional Psychology, 12*, 740-748.

Bernard, J.M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Upper Saddle River, NJ: Pearson Education.

Blackburn, I. M., James, I.A., Milne, D.L., Baker, C., Standart, S., Garland, A., & Reichelt, K. (2001). The revised cognitive therapy scale (CTS-R): Psychometric properties. *Behavioural and Cognitive Psychotherapy*. *29*, 431-446.

Brosan, L., Reynolds, S., Moore, R.G. (2006). Factors associated with competence in cognitive therapists. *Behavioural and Cognitive Psychotherapy*, *35*, 179-190.

Butler, C. A., Lask, J., Sheils, L., Crossley, J., Joscelyne, T., & Pote, H. (2018). Measuring competence in systemic practice: development of the 'systemic family practice – systemic competency scale' (SCS). *Journal of Family Therapy*, *0*, 1-21.

Carmel, A., Villatte, J. L., Rosenthal, M. Z., Chalker, S., & Comtois, K., A. (2016). Applying technological appoaches to clinical supervision in dialetical behaviour therapy: A randomised feasibility trial of the Bug-in–the-Eye (BITE) Model. *Cognitive Behavioural Practice*, *23*, 221-229.

CASP. (2013). *Critical Appraisal Skills Programme*: *Qualitative Research Checklist*. Retrieved from http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf:

Centre for Reviews and Dissemination (2009). *Systematic reviews: CRD's guidance for undertaking reviews in health care.* York, UK: University of York. Retrieved from https://www.york.ac.uk/crd/guidance/

De Stefano, J., D'Iuso, N., Blake, E., Fitzpatrick, M., Drapeau, M., & Chamodraka, M. (2007). Trainees' experiences of impasses in counselling and the impact of group supervision on their resolution: A pilot study. *Counselling and Psychotherapy Research*, *7*, 42–47.

Falender, C.A. & Shafranske, E. P. (2004). *Clinical Supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Friedlander, M. L., & Ward, L. G. (1984). Development and validation of the Supervisory Styles Inventory. *Journal of Counseling Psychology*, *31*, 541-557.

Gonsalvez, C. J., Hamid, G., Savage, N. M., & Livni, D. (2017). The supervision evaluation and supervisory competence scale: psychometric validation. *Australian Psychologist*, *52*, 94-103.

Heckman-Stone, C. (2004). Trainee preferences for feedback and evaluation in clinical supervision, *The Clinical Supervisor*, *22*, 21-33.

Higgins, J. P., & Green, S. (2011). *Cochrane handbook for systematic reviews of interventions*. Wiley-Blackwell.

Johnston, L.H., & Milne, D. (2012). How do supervisee's learn during supervision? A grounded theory study of the perceived developmental process. *The Cognitive Behavioural Therapist*, *5*, 1-23.

Kilminster, S. M., & Jolly, B. C. (2000). Effective supervision in clinical practice settings: a systematic review. *Medical Education*, *34*, 827-840.

Kaslow, N. J., Borden, K. A., Collins, F. L., Jr., Forrest, L., Illfelder-Kaye, J., Nelson, P., Rallo, J.S., Vasquez, M.J.T. & Willmuth, M.E. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology, 60,* 699-712.

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counselling Development*, *77*, 447–455.

Lau, N., & Weisz, J.R. (2012). *Manual for the cognitive behavioural therapy competence observational measure of performance with youth depression (CBTCOMP-YD)*. Unpublished manuscript, Department of Psychology, Harvard University, Cambridge,
MA.

Martino, S., Paris, M., Afiez, L., Nich, C., Canning-Ball, M., Hunkele, K., Olmstead, T., & Carroll, K. M. (2016). The effectiveness and cost of clinical supervision for motivational interviewing: A randomised controlled trial. *Journal of Substance Abuse Treatment, 68*, 11-23.

Milne, D., & James, I. (2000). A systematic review of effective cognitive-behavioural supervision. *British Journal of Clinical Psychology*, *39*, 111-127.

Milne, D. (2007). An empirical definition of clinical supervision. *British Journal of Clinical Psychology,46,* 437–447.

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., … PRISMA-P Group. (2015) Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic Reviews*, *4*, 1-9.

Nel, P. W., Pezzolesi, C., & Stott, D. J. (2012). How did we learn best? A retrospective survey of clinical psychology training in the United Kingdom. *Journal of Clinical Psychology, 68*, 1058-1073.

National Institute for Health and Care Excellence (NICE). (2012). *The guidelines manual*. Retrieved from https://www.nice.org.uk/process/pmg6/chapter/identifying-the-evidence-literature-searching-and-evidence-submission

O'Donovan, A., Halford, W. K., & Walters, B. (2011). Towards best practice supervision of clinical psychology trainees. *The Australian Psychological Society*, *46*, 101-112.

Ogren, M. L., & Jonsson, C. O. (2004). Psychotherapeutic skill following group supervision according to supervisees and supervisors. *The Clinical Supervisor*, *22*, 35-58.

Olsson, G. (1996). Self-esteem out of balance: A study of therapy students' comprehension of their skills. *Nordisk Psykologi*, *48*, 252-265.

Palomo, M., Beinart, H., & Cooper, M. J. (2010). Development and validation of the Supervisory Relationship Questionnaire (SRQ) in UK trainee clinical psychologists. *British Journal of Clinical Psychology*, *49*, 131-149.

QSR International Pty Ltd. (2012). NVivo qualitative data analysis software. (*Version 10)*.

Rakovshik, S. G., & McManus, F. (2013). An anatomy of CBT training: trainees' endorsements of elements, sources and modalities of learning during a postgraduate CBT training course. *Education and Supervision*, *6*, 1-12.

Rakovshik, S. G., McManus, F., Vazquez-Montes, M., Muse, K., & Ougrin, D. (2016). Is supervision necessary? Examining the effects of internet-based CBT training with and without supervision. *Journal of Consulting and Clinical Psychology*, *84,* 191-199.

Roth, A. D., & Pilling, S. (2007). A competence framework for the supervision of psychological therapies [electronic version]. Retrieved from http://ww.ucl.ac.uk/clinical-psychology/CORE

Rousmaniere, T., & Frederickson, J. (2013). Internet-based oneway-mirror supervision for advanced psychotherapy training. *The Clinical Supervisor*, *32*, 40–55.

Scott, T., Pachana, N., & Sofranoff, K. (2011). Survey of Current Curriculum Practices within Australian Postgraduate Clinical Training Programmes: Students' and Programme Directors' Perspectives. *Australian Psychologist*, *46*, 77–89.

Sharpless, B. A. & Barber, J. P. (2009). A conceptual and empirical review of the meaning, measurement, development, and teaching of intervention competence in clinical psychology. *Clinical Psychology Review*, *29*, 47-56.

Steward, R. J., Breland, A. & Douglas, M., N. (2001). Novice supervisees' self-evaluations and their perceptions of supervisor style. *Counsellor Education & Supervision, 41*, 131-141.

Stolenberg, C.D. (2005). Enhancing professional competence through developmental approaches to supervision. *American Psychologist*, *60*, 857-864.

Tanner, M. A., Gray, J. J., & Haaga, D. A. (2012). Association of cotherapy supervision with client outcomes, attrition and trainee effectiveness in a psychotherapy training clinic. *Journal of Clinical Psychology, 68*, 1241-1252.

Thomas, B., Ciliska, D., Dobbins, M., & Micucci, S. (2004). A process for systematically reviewing the literature: Providing the research evidence for public health nursing interventions. *Worldviews on Evidence-Based Nursing, 1*, 176-184.

Tweed, A., Graber, R., & Wang, M. (2010). Assessing trainee clinical psychologists' competence. *Psychology Learning & Teaching*, *9*, 50-60.

University College London (UCL). (2019). *UCL competence framework*. Retrieved from: https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks

Vallance, K. (2004). Exploring counsellor perceptions of the impact of counselling supervision on clients. *British Journal of Guidance and Counselling*, *32*, 559–574.

Watkins, C. E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor*, *30*, 235-256.

Weck, F., Jakob, M., Neng, J., M., B., Hofling, V., Grikscheit, F., & Bohus, M. (2016). The effects of Bug-in-the-eye supervision on therapeutic alliance and therapist competence in cognitive-behavioural therapy: A randomised controlled trial. *Clinical Psychology and Psychotherapy*, *23*, 386-396.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, *7*, 54-65.

Wilson, H. M. N., Davies, J. S., & Weatherhead, S. (2016). Trainee therapists' experiences of supervision during training: A meta-synthesis. *Clinical Psychology and Psychotherapy*, *23*, 340-351.

Winstanley, J., & White, E. (2011). The MCSS-26: revision of the Manchester clinical supervision scale using the Rasch measurement model. *Journal of Nursing Measurement*, *19*, 160-178.

Appendices

Appendix A: Example search strategies (PsycInfo and ASSIA)

Appendix B: EPHPP full table

Appendix C: CASP full table

Appendix D: Journal guidelines (The Clinical Supervisor)

Appendix A

Example search strategies

PsycInfo

1 Exp Therapist Trainee/

2 (Trainee* adj2 therap*).ti,ab.

3 (trainee* adj2 Psycholog*).ti,ab.

4 (Trainee practitioner* or Psychology practitioner*).ti,ab.

5 1 or 2 or 3 or 4

6 exp Professional Supervision/

7 (Supervis* or "Clinical Supervis*").ti,ab.

8 6 or 7

9 exp PROFESSIONAL COMPETENCE/

10 (competence* or experience* or perception*).ti,ab.

11 9 or 10

12 5 and 8 and 11

ASSIA

MAINSUBJECT.EXACT.EXPLODE("Therapists") or ("trainee NEAR/2 Therap*") or ("trainee NEAR/2 Psycholog*") or ("trainee NEAR/2 practitioner*") or ("psychology practitioner")

MAINSUBJECT.EXACT("Professional competence") OR MAINSUBJECT.EXACT("Perceived competence") OR ("competence*")

MAINSUBJECT.EXACT("Supervision") OR ("professional supervision") OR ("clinical supervision")

(MAINSUBJECT.EXACT.EXPLODE("Therapists") OR ("trainee NEAR/2 Therap*") OR ("trainee NEAR/2 Psycholog*") OR ("trainee NEAR/2 practitioner*") OR ("psychology practitioner") .noft)

AND (MAINSUBJECT.EXACT("Professional competence") OR MAINSUBJECT.EXACT("Perceived competence") OR ("competence*") OR ("experience*") OR ("perception*") .noft) AND (MAINSUBJECT.EXACT("Supervision") OR ("professional supervision") OR ("clinical supervision") .noft)

Appendix B

Table 3. EPHPP quality rating full

No.	Reference	A- Selection Bias	B- Study Design	C- Confounders	D- Blinding	E- Data Collection Method	F- Withdrawals and dropouts	Overall rating
1	Bearman, Schneiderman & Zoloth, 2017	2	1	1	2	1	1	Strong
2	Brosan, Reynolds & Moore, 2006	3	3	3	3	1	n/a	Weak
3	Carmel et al., 2016	2	1	3	2	1	1	Moderate
5	Martino et al., 2016	1	1	3	1	1	1	Moderate
7	Ogren &Jonsson, 2004	3	3	3	3	3	n/a	Weak
8	Rakovshik & McManus, 2013	1	2	3	3	1	n/a	Weak
9	Rakovshik et al., 2016	2	1	3	2	1	n/a	Moderate
10	Steward, Breland & Neil, 2001	2	2	3	3	1	n/a	Weak
11	Weck et al., 2016	2	1	3	1	1	1	Moderate

Note: 1 = Strong, 2= Moderate, 3 = Weak

Appendix C

Table 4. CASP Overall table

No.	Reference	Validity Aims	Validity Methodology	Validity Design	Validity Recruitment	Validity Addresses Research Questions	Validity Researcher role	Results Ethical issues considered	Results Rigorous	Results Clear statement findings	Results Valuable	Overall rating
4	Johnston & Milne, 2012	Y	Y	CT	N	Y	N	CT – somewhat	Y	Y	Y	6/10
6	Nel, Pezzolesi & Stott, 2012	Y	Y	Y	CT	Y	N	N	Y	Y	Y	7/10

Note: Y= Yes, N= No, CT = Cannot tell

Appendix D

Copy of journal guidelines for authors for the nominated journal, The Clinical Supervisor

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 30 pages, inclusive of the abstract, tables, references, figure captions.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

All parts of the manuscript should be typewritten, double-spaced, and have margins of at least one inch on all sides. Manuscript pages should be numbered consecutively throughout the paper and include a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Authors are to avoid abbreviations, diagrams, and reference to the text in the abstract.

References

Please use this reference guide when preparing your paper.

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Checklist: What to Include

Author details. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.

Should contain an unstructured abstract of 100 words.

You can opt to include a video abstract with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.

Between 3 and 8 keywords. Read making your article more discoverable, including information on choosing a title and search engine optimization.

Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:

For single agency grants

This work was supported by the [Funding Agency] under Grant [number xxxx].

For multiple agency grants

This work was supported by the [Funding Agency <] under Grant [number xxxx]; [Funding Agency >] under Grant [number xxxx]; and [Funding Agency &] under Grant [number xxxx].

Disclosure statement. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.

Biographical note. Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief (e.g. no more than 50 words).

Data availability statement. If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.

Data deposition. If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

Supplemental online material. Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

Figures. Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.

Tables. Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

Equations. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.

Units. Please use SI units (non-italicized).

SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

Student and Supervisor Experiences of the Systemic Practice Scale (SPS) Measure: A Discourse Analysis

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Target Journal: Journal of Family Therapy

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Abstract

There has been a recent emphasis on the assessment of competence in clinical training courses to improve evidence-based practice and outcomes for clients. The systemic practice scale (SPS) was developed as a structured way to evaluate systemic practice. There is however little research on the impact and experience of competence measures particularly within the context of systemic practice.

Focus groups conducted with students and supervisors from systemic family practice (SFP) programmes explored their views of the SPS as an appropriate measure of systemic competence. Three dominant discourses were identified: *feedback as valuable*, *measuring competence*, and *being systemic*. These discourses recognised the usefulness of a scale to measure systemic competence but also the tensions that this raised for both students and supervisors.

Clinical and practice implications for the use of the SPS in assessing systemic competence need to be considered in line with the values of systemic practice, maintaining reflexivity and collaboration between the student and supervisor in order for the feedback to have a meaningful impact on student development.

Key words: Competence, Discourse analysis, Supervision, Systemic Practice

Introduction

Competence Based Practice and the Systemic Context

Competence-based practice has become a focus of evaluation for trainees across clinical training courses to ensure safe and effective practice (Gallichan & Mitchell, 2008; Roth & Pilling, 2007; Sutherland, Fine & Ashbourne, 2012). Competence in the context of psychotherapy has been defined as “a standardised requirement for an individual to perform a specific job” (Stratton et al., 2011, p.123). Gallichan & Mitchell (2008) suggest competence is “a multi-faceted construct: it is more than how someone thinks, but it is also more than what someone does” (p.18). The formal purpose of assessing an individual’s competence is to provide helpful, meaningful and constructive feedback for the individual to reflect on their clinical skills, highlighting possible areas of development (O’Donovan, 2015).

Assessment of a trainee’s competence is argued to be a developmental and contextually based process extending from training into qualified practice. This process is dependent on supervision, formative and summative assessment and the therapy modality (Epstein & Hundert, 2002; Tweed, Graber & Wang, 2010). Self-report during supervision is the predominant method of assessing clinical competence (Scaife, 2003; Tweed et al, 2010). Within supervisory interactions trainees develop knowledge, understanding and competence (Bernard & Goodyear, 2014; Burnham, 2018; Scaife, 2003). In addition supervision can alleviate signs of distress, burnout and self-criticism which are factors thought to impact trainee competence (Ladany, Mori & Mehr, 2013; Wilson, Davies & Weatherhead, 2016).

Within a systemic context Anderson and Swim (1995) suggest learning in supervision is interactional, where new knowledge and competence evolves through

dialogue and relational reflexivity. Some have suggested competence-based training challenges this systemic paradigm of interaction and locates competence solely within the individual irrespective of the context (Simon, 2010; Sutherland et al., 2012). Simon (2010) discusses the challenges systemic supervisors have working within training courses that are "dominated by inflexible professional narratives" (p.308) that may not fit within a culture where micro-measurement of clinical practice has become the norm (Butler et al., 2018; Tweed et al, 2010). Sutherland et al. (2012) argued from a social constructionist perspective "what is 'noticed' will depend in part on the observer's theoretical and philosophical commitments" (p.3). Some have questioned whether the use of a specific systemic competence scale would capture the contextual layers of systemic practice (Moran, 2017), providing "a limiting or reductionist view" (Butler et al., 2018, p.3).

The introduction of the improving access to psychological therapies (IAPT) programme in 2008 saw the establishment of competence frameworks for the practice of effective evidence based psychological therapies (Clinical Outcomes in Routine Evaluation, CORE, 2017). A number of psychometric scales exist to assess competence, such as the widely used cognitive therapy scale (CTS-R, Blackburn et al., 2001), however these initiatives came primarily from the cognitive behaviour therapy (CBT) models and within the field of systemic therapy up until recently there had not been an equivalent.

The systemic practice scale (SPS[1]) was developed in response to current changes in the delivery of mental health services for child and young person's IAPT (CYP-IAPT) and the lack of measures to assess systemic competence (Butler et al.,

[1] The SPS was initially titled the Systemic Family Practice – Systemic Competency Scale (SFP-SCS)

2018). It is used within CYP-IAPT systemic family practice (SFP) courses across the UK, providing a structured assessment of systemic skills that can be used in supervision or as a training tool (Butler et al., 2018, Appendix A). The measure consists of twelve items to assess supervisees' competence across a number of domains such as, interpersonal effectiveness, collaboration and use of questioning. A small-scale study demonstrated high internal reliability (Intraclass Correlation Coefficient (ICC) 0.94 ((CI: 95% 0.89-0.97) $F (22, 297) = 20.36$, $p<0.001$)) and reported the measure held face validity based on use within CYP-IAPT training courses (Butler et al., 2018). The study included a thematic analysis of 23 supervisors' experiences of using the scale. Supervisors reported the SPS was a helpful way to give feedback to students but recognised this approach required flexibility in providing "feedback beyond the scale" (Butler et al., 2018, p.16).

There is limited research on the lived experience of clinical trainees training, particularly in the context of systemic practice (Nel, 2006). Nel (2006) provided a qualitative account of the experiences of training as a family therapist and found students reported training as "overwhelming and de-skilling, but that it nevertheless provoked a re-evaluation of some of their established personal, relational and professional identities" (p. 307).

Discourse Analysis and Systemic Practice

Discourse analysis (DA) is concerned with how the use of language is implicated in the construction of versions of events (Willig, 2014). DA emphasises how social reality is achieved through the construction and function of language as a tool of social action (Georgaca & Avdi, 2012). DA prioritises reflexive ideology and practice (Avdi, 2005). Both DA and systemic approaches draw from a shared

theoretical basis in social constructionism (Tseliou & Borcsa, 2018), whereby reality and meaning "are systematically constructed and maintained through systems of meaning and through social practices" (Georgaca & Avdi, 2012, p. 2). Social constructionism influences in systemic practice have emphasised the "role of language and multiple layers of context" (Tickle & Rennoldson, 2016, p.127). In systemic practice it is acknowledged "the therapist's ways of viewing the world, our talk and ways of acting powerfully affect the therapeutic conversation and the client" (Hedges, 2005, p.26). Systemic approaches are driven by the context and systems of interactions (Bronfenbrenner, 1979; Burck, 2005) which is acknowledged in DA (Gee, 2014; Georgaca & Avdi, 2012).

Through a DA framework attention is given to the effects of the choice of words used to express or describe something (Willig, 2014). Georgaca & Avdi (2012) consider the impact of *subject positions* within DA and how these influence the function of talk but also the content (Davies & Harre, 1990), through asking "who speaks? In whose name do they speak? Who do they address? Who do they speak for?" (Georgaca & Avdi, 2012, p.155). Systemic practice draws on the concept of subjectivity and how discourses shape relationships and interactions. Burck (2005) highlights how "the notion of 'discursive practices' addresses questions of agency through critically examining ways individuals position themselves and are positioned through language" (p.251).

Discourses can be identifiable and produced through pre-conceived institutional practices such as frames of reference e.g. roles and expectations in clinical settings. DA enables consideration of the wider contextual factors that may influence clinical understanding (Georgaca & Avdi, 2012; Potter & Wiggins, 2007). Roy-Chowdhury's (2006) work examining systemic therapy through DA interestingly

orientates the analysis towards positioning whilst “maintaining an awareness of the ways in which speech constitutes and represents the negotiation of identities, psychological states, power relations and social and institutional structures” (p.157). The present study is grounded within DA and systemic theory through a shared theoretical social constructionist approach.

Aims and Research Questions

Assessing the competence of practitioners delivering systemic therapy remains important in maintaining validity of treatment for clients, demonstrating effectiveness of training and assisting therapists in their clinical development. There is little research on the impact and experience of competence measures particularly within the context of SFP. The current study aims to expand this area of research to gather the perspectives of supervisors’ and students’ experiences using the SPS.

The present study aimed to explore student and supervisor experiences of the SPS using a DA framework. The following research questions guided the analysis:

1. Do systemic students and supervisors view the SPS as an appropriate way of assessing systemic competence?
2. How are discourses regarding systemic competence (in reference to the SPS) constructed within the context of systemic training?

Methodology

Design

A qualitative focus group design was used and data were analysed using DA methodology.

Participants

Recruitment was purposive, students and supervisors from four SFP programmes across the UK were invited to participate (Table 1). A course requirement from all sites was the completion of the SPS at three time points across the academic year. Three video recordings of clinical work with families/couples were submitted by students, which are subsequently rated by supervisors using the SPS. The process of receiving feedback from the SPS varied; in addition to individual written feedback, some received verbal group feedback.

Five focus groups were held across two sites; three student groups and two supervisor groups. Supervisors and students participated in separate focus groups. All participants were asked to complete a demographic questionnaire, derived specifically for this study (Appendix B). A semi-structured topic guide (Appendix C) guided group discussions, facilitated by the researcher in order to actively encourage group members to contribute to group discussions (Wilkinson 2008). The topic guide was based on the reflective section of the SPS developed by a training course within the SW of England and through discussions with SFP practitioners. A pilot focus group was conducted with five SFP students to check the structure and clarity of questions asked. The topic guide was slightly amended when interviewing the supervisors (See Appendix C).

All groups were audio-recorded and transcribed verbatim using Jefferson notation (Jefferson, 2004; Appendix D).

Table 1

Summary of Participants Included within each Focus Group

Group	Date	Participant profile	Number of participants	Age (years) Mean (SD) Range	Gender	Length in current role (years) Range
1	September 2018	Student	5	41.6 (10.7) 31-56	5 Women	1-4
2	October 2018	Supervisor	3	54.7 (6.7) 45-60	1 Man 2 Women	5-29
3	November 2018	Student	7	42.4 (7.8) 28-52	1 Man 6 Women	4-12
4	November 2018	Supervisor	4	53.3 (8.9) 42-62	1 Man 3 Women	1-5
5	November 2018	Student	4	38.5 (2.7) 34-41	1 Man 3 Women	2-4
		Totals:	23	45.0 (10.0) 28-62	4 Men 19 Women	1-29

*Note: SD, Standard Deviation

Procedure and Ethical Considerations

Ethical approval was granted from the School of Psychology Research Ethics Committee at the University of Exeter (Appendix E).

The study was discussed with course leads across the sites of recruitment for approval to disseminate information to students and supervisors. The information sheet and consent forms (Appendices F-H) were distributed through the administration team, inviting participants to take part in the focus group. Groups were scheduled to ensure students had received feedback from at least two SPS.

Informed consent was obtained from all participants prior to conducting the group and all participants were informed of their right to withdraw from the study. Confidentiality and anonymity are issues raised when conducting focus groups due to the nature of group participation (Smithson, 2018). Participants were made aware within the information sheet and again at the beginning of each group, of the limitations of confidentiality in a group setting and the importance of respecting group members' views.

Data Analysis

Data collected through focus groups were analysed using DA following Potter and Wiggin's guide to DA (Potter & Wiggins, 2007;Appendix I) and informed by Georgaca and Avdi's five levels of DA (Georgaca & Avdi, 2012; Appendix J).

Focus groups are advantageous in enabling pre-existing groups of individuals with shared characteristics to discuss a topic of interest (Wilkinson, 2008). DA enables the exploration of group talk and the use of rhetorical strategies to achieve particular outcomes (Duggleby, 2005; Potter & Wetherell, 1987). There are several explicit and implicit factors thought to affect group dynamics including power, positioning of role, hierarchies and experts as well as emerging consensus (Smithson, 2018).

Due to word count limitations, the analysis focused on how group participants used rhetorical strategies within group interaction to position themselves and others in the group (Georgaca & Avdi, 2012; Potter & Wiggins, 2007). The analysis focused on the group talk discourses regarding the SPS within the context of their systemic practice (Burck, 2005; Roy-Chowdhury, 2010).

The process of analysis involved an initial submersion within the data, reading and re-reading the transcripts. Transcripts were coded within NVIVO (QSR, 2012) which enabled a systematic approach to the analyses and the identification and interpretation of patterns in the discourse (Potter & Wetherell, 1987). Key discourses associated with the research questions were identified and extracts are presented in the findings to illustrate these and the discursive practices used (Jorgensen & Phillips, 2002). Georgaca and Avdi (2012) propose five levels at which DA can occur (Appendix J, Table 2). These levels were utilised as a guide within the current analysis enabling a flexible approach to the iterative process. Although all levels were considered, the analysis focused on level 2 (the function of language within the groups) and level 3 (how language was used to position group members).

Quality Criteria

Evaluative criteria consistent with DA's epistemological approach were considered in order to appraise the quality of the research (Georgaca & Avdi, 2012). They suggest five useful evaluative criteria: *internal coherence*, to ensure there is consistency in the data presented, forming a coherent narrative; *rigour*, through attention to inconsistency. Data needs to be *transparent and situated* ensuring the stages of research are clear and the extracts are grounded within the analysis enabling the reader to draw judgements on both the quality and findings themselves. *Reflexivity,* in the process, by the researcher attending to their role and bias and finally the *usefulness* of the data and wider implications. A reflexive diary was kept throughout recruitment and analysis to maintain transparency of the process and my role.

To ensure fidelity to the DA approach extracts of the data were presented at a DA group where group analysis and discussion took place. In addition, my supervisor, who was a discourse analyst, reviewed extracts. These processes aimed to mitigate issues raised previously on the reflexivity of the researcher position and gain further perspectives on the work. This allowed for critical appraisal and evaluation of the work in line with the DA methodological approach.

Results

Five focus groups were conducted across two sites. Groups consisted of either students currently enrolled on the SFP training or supervisors of those courses. The length of groups ranged from 34 to 52 minutes with the average group lasting 42 minutes.

The majority of participants were women with varied lengths of experience within their current role. All students were experienced practitioners with varied backgrounds and current roles, including clinical psychologists, social workers, primary mental health workers and systemic family practitioners.

Analysis

The following section discusses 11 extracts selected from across the five focus groups. The extracts are organised by three dominant discourses, *feedback as valuable*, *measuring competence* and *being systemic*. For each discourse where possible both the student and supervisor perspective are presented. Brackets after words indicate line references in extracts. In line with the DA approach, extended extracts are presented to enable the reader to judge the coherence and plausibility of the analysis which is discussed alongside relevant literature (Georgaca & Avdi, 2012; Potter & Wiggins, 2007).

Feedback as valuable

The implicit purpose of assessing an individual's competence is to provide feedback that enables individuals to reflect on their practice (O'Donovan, 2015). In all student groups the process of receiving feedback and the value of this was reflected on. The following extracts present the student and supervisor discourse of feedback as *valuable.* Extract one comes from the beginning of focus group (FG)

one. The students were asked an open-ended question by the researcher to share their experiences of receiving feedback from the SPS.

Extract 1: FG1 Students

Sarah[2]: (…5…) ((group laugh)) ˚Um I think I was saying before that um it's a bit scary receiving feedback because we know it's going to be really valuable but the fact someone has sat and watched you for an hour and has made all these comments and might you might have thought you've done something well and they might have thought it wasn't ↑ quite as good as what you thought, that can be a bit scary, because it's personal isn't it? It's not anonymous like the rest of our work˚

R[3]: Yeah so they can physically [yeah see you in your tape

((All nod)) Sarah: yeah]

Victoria: It does kind of seem like well it does to me the most valuable (…) feedback that we get rather than you know the feedback from essays. <u>That that</u> feedback was what I was really <u>really</u> waiting for and really wanting to find out about, wanting to sort of even though even though (…) dreading it wanting to get those observations. Spend that time reflecting on yourself which is really so important

[2] All names and identifying features have been changed and pseudonyms used to protect anonymity of participants and places.
[3] Note: 'R' refers to the researcher

A dominant discourse evidenced within extract one is how students viewed the feedback as “valuable”. Victoria’s repetitive use of the word “really” (17) functions to reiterate the importance of the feedback. The students switch between the use of ‘I’ to ‘we’ as a potential way of maintaining solidarity and collaboration of the group position on receiving feedback (Donohue & Diez. 1985).

Sarah’s use of the wording “valuable, but...” (8) indicates that there is an assumption or training norm that the feedback is valuable however the use of “but” suggests some discomfort with the idea that the measure is unquestionably valuable. Similarly the pause in line 15 by Victoria could reflect this uncertainty.

The group also refer to the feedback as “scary” (8) and “dreading it” (19). The discomfort of receiving feedback is not uncommon, sometimes leaving trainees feeling de-skilled (Nel, 2006). Although the students do not refer to this, the extract highlights the exposing nature of being observed and judged and the uncertainty this creates, highlighted by the question asked by Sarah (13).

As the discussion progresses some group differences arise in how the measure is viewed as “valuable”. Extract two highlights two contrasting views, this discussion comes after the students had been asked if they felt the measure impacted their competence in systemic practice.

Extract 2: FG1 Students

Harriet: I think it does when I’ve used it it definitely highlights areas I think really need to focus on developing my skills in so it’s that bit of um (…) good at helping you to develop what you need to develop however hard it is to sort of (…) your really not good at that but it’s a nudge isn’t

it that if you want to be good at <u>your job</u> this is ˚an invitation to learn how to get better at it˚

Laura: but I see it completely differently I see it as a paper exercise that you have to do as part of <u>the course</u> [R: yep] ˚and actually˚ (…) <u>I use</u> my supervision thinking about what I need to improve (…) so I think for m:e if they really want it to be (.) collaborative experience then maybe they should bring it into supervision that we have at university a bit more so that then if we were having supervision and they watch a bit of our tape they could say well (…) if you were thinking about x section on the scale where would you scale yourself and why would you do that so that they could link it into supervision because it does j:ust feel like it's a paper exercise tagged on it doesn't feel very collaborative with the other kind of stuff we do around looking at how we are getting on with our practice in supervision

Sarah: ˚I think um I was just thinking about whether I took it back into practice and˚ ↑actually I think that I really agree it would be really helpful to have it referenced more in supervision both here at the uni and in the workplace

Harriet begins by re-emphasising the value in the feedback received in developing systemic skills. She uses a qualifier "however" (120) to indicate the imagined anxiety of being told what you're "not good at", reframing it as a "nudge" (121). She poses this in a question to the group "isn't it" (121), possibly seeking reassurance and approval in her view point. Nel (2006), found participants were presented with dilemmas throughout their systemic training to re-evaluate their

professional identities through the new knowledge and skills of the course. The "nudge" Harriet discusses could be a reference to this re-evaluation of identity as all the students are already qualified practitioners.

In contrast Laura offers an opposing view to the group, presenting the measure as a "paper exercise" (124), locating it as part of the context of the course that is not "collaborative" (127 and 133). Laura states how "actually I use my supervision…" (125) interrupting the discourse of the measure as valuable in guiding the process of development and inviting the supervision context as a place to consider competence. Laura invites a different perspective of the use of the measure in collaboration with the supervisors, rather than being "tagged on" (133).

Later within the same focus group this perspective of collaboration of the supervisor and student perspective is acknowledged further, "I kind of feel it's a very sort of undervalued resource in a way that I can really see you saying you had a conversation with your supervisor about your scores and how you could change it if you had the time to do that would be such a valuable kind of resource" (186-188). This acknowledges the importance of the supervisory relationship to support student development through feedback and discussion (Anderson & Swim, 1995; Sutherland et al., 2012).

Extract 3 shares part of a discussion between the supervisors about their relationship in the process of feedback. The extract follows a discussion regarding the marking process of the measure.

Extract 3: FG2 Supervisors

306 Stuart: the feedback so we don't have the feedback

307 R: the loop

308 Stuart: so we're saying that the the SPS might be effective and might be
309 useful scale but we are not necessarily using it as well as we could do
310 ↑but we've got limited resources though ((laughs)) lets lets be blunt
311 (inaudible)

312 Abi: well you know people don't bring clips you know

313 Stuart: [yeah

314 Ceri: but more than that they should be bringing it to their clinical supervision
315 their workplace supervision [Abi: yeah] and saying look I've just scored
316 really high

317 Stuart: Yeah yeah]

318 Ceri: on this and this I need to work on this and this

Here the supervisors discuss how the feedback from the SPS "might be effective and might be useful" (308) alongside feedback within supervision. The use of the language "let's be blunt" (310) positions Stuart as pragmatic and solution-focused, whilst communicating the challenges of the course context and the impact of "limited resources" (309-310). The extract introduces the wider expectations of the course and the workplace (Simon, 2010). The emphasis on "well" indicates a frustration of what then Ceri states as what the students "should" be using the feedback from the measure for in clinical supervision. The supervisors imply students should take a sense of responsibility (312-315), in contrast Laura (extract 2), a student suggests a responsibility of the supervisor to "bring it into supervision" (126-127), a possible tension between the two.

Interestingly the supervisor perspective differed between courses (extract 4). This extract comes midway through a discussion regarding the different ways the supervisors used the measure in supervision groups.

Extract 4: FG4 Supervisors

Harry: As we are talking, I'm wondering to myself now whether it's less useful in supervision. Well, not wondering. I'm certainly coming to a view that it's less useful as a supervision tool than it is as a rating evaluation tool and in some ways maybe it's a bit constraining to use it in supervision because it almost feels like you've got to find something to say on every bit and actually it doesn't encourage the dialogue. I know we are constrained by time and if we've got to watch the whole one hour then we've got limited time to talk about it anyway but I wonder whether that framework, maybe it's not that conducive to giving useful feedback sometimes.

Amy: And I think sometimes for me it's about filling it in for filling it in's sake, it's getting finished in the time and putting something in every box that if I was free to write my own notes, or had fewer headings or a different approach, I might do that differently and that might be more useful.

Harry: Yes, yes.

Amy: Yes, I don't know.

Laura: I'm wondering if there's a bit of a both and… because I actually agree with everything you've said and I'm wondering whether giving them notes on the systemic competency scale means that they get used to

seeing it and get used to seeing the sections and the title and how we break the session down so that when they come to then review their own tapes for submission, that’s how they learn

Harry begins by querying the use of the measure within supervision as "constraining" (438) and potentially "less useful" (435-436). Amy follows this with "filling in for filling it in sake" (445), potentially building on this idea of the measure as constraining and restricting the process of supervision. A similar view voiced in the previous supervisor group (Extract 3).

The extract evidences shifts in positioning through the use of pronouns. Harry uses the first person when discussing his position on the use of the measure in supervision e.g. "I'm wondering…." (435), "I'm certainly…" (436) and then switches to "we" when referencing the course context "we are constrained by time" (440). This enables his perspective to be voiced without implying this is necessarily a view universally accepted by the group. The extract also evidences explicit focus group talk of agreement between the supervisors (451-452).

Measuring competence

The concept of whether measuring competence of systemic principles would be able to encapsulate the many contextual levels has been previously questioned (Moran, 2017). The following extracts highlight this dilemma considering the discourse of *measuring competence* in the wider context and the subjective nature of the "what is noticed" (Sutherland et al., 2012).

Extract 5 comes from midway through a discussion regarding how the measure fitted within the context of the therapy session for students.

Extract 5: FG3 Students

530 Josie: ˚The competency scale is very pure and I don't think its real life˚.

531 Charlotte: It's a bit too black and white, a bit like you can do it or you can't
532 do it.

In this brief extract, Josie describes the measure as "pure" not "real life" (530), reaffirmed by Charlotte as, "too black and white" (531). The language suggests a "purity" and linearity to the measure which contradicts the "real life" context and layers Moran (2017) argues are an integral part of the systemic model.

The dilemma of the wider context is further evidenced within extract 6. This extract comes from the middle of FG1 and introduces the challenge of the subjectivity interpretation of the SPS invites. The students had been discussing how they felt the SPS had affected their practice in the context of the university and workplace.

Extract 6: FG1 students

165 Harriet: It changes your lens doesn't it so if you're reviewing your sessions
166 looking at some of the domains or all of the domains it kind of changes
167 your focus so I could for example look at a tape and think and see
168 certain stuff but then if I just had just been reading about intervening in
169 process then I could watch it again and think oh I could have
170 intervened there… so it kind of it wakes you up to things you could be
171 blind to or unaware of

172 Victoria: I was just … sorry

Laura: I suppose I just feel it is a snapshot it's just one tape in amongst all the others that you've got so I suppose Yeah I've always got that in the back of my mind as I said earlier it's that you know what you score in one session could be very different to what you score in another so you have to take it slightly from that perspective you know we're probably not going to score very well for all 12 for every session but that doesn't mean to say that you haven't got competence and actually I wonder if there's another way of working out with all the work that you do rather than just basing it on three tapes

Harriet highlights how the measure "changes your lens doesn't it" (165). The intonation and rhetorical question used invites the group to consider this perspective and could be viewed as a strategy to seek validation from the group. The use of the term "lens" implies a way to observe a situation, within systemic practice the focus is on gaining different perspectives in order to create meaning (Anderson & Swim, 1995). This introduces the theoretical concept of subjectivity of the "lens" that is chosen to view the behaviour and the implications of this.

A systemic principle lies in the relational nature of action, Jones (2003) discusses how "causation can only be thought of as circular, i.e. behaviour is subject to constant modification in relation to feedback; that knowledge is brought forth by the subjectivity of the observer" (Jones, 2003, p.349). In this context the feedback provided by the SPS also modifies the subjectivity of the observer (supervisor) but also of the students being observed. Harriet goes on to highlight how the measure "wakes you up to things you could be blind to or unaware of" (170-171) again reiterating the impact using the SPS can have on practice, although this is qualified with "so it kind of" (170) suggesting some ambivalence to this.

Laura positions herself as not explicitly disagreeing with Harriet, through the use of “I suppose” (173). The language used reiterates the discourse of subjectivity in the scores students receive from one session to the next (175-176), describing the SPS as a “snapshot” (173; Butler et al., 2018). Laura discusses how it “doesn’t mean to say that you haven’t got competence” (179) reiterating the subjective nature of interpretation of competence through the context of the session but also the perspective or lens of the supervisor observing. Similarly, students within FG3 discussed the subjectivity of the measure as being “open to interpretation” (134) depending on the context and perspective of the supervisor marking (Simon, 2010).

The challenge of measuring competence appears to be an uncontested discourse amongst the student focus groups, further evidenced in Extract 7. This extract follows a discussion of the challenges students faced when ensuring the 12 items of the SPS were met competently in sessions.

Extract 7: FG3 Students

933 Emma: It ju:st feels too fake in a way,

934 George: [Yeah

935 Emma: doesn’t it, just this random session you are marked on when really

936 ((laughs)).

937 Katy: It’s not reflective of where you are up to, maybe,

938 Emma: [But it’s not no:

939 Katy: or that you feel that you are up to.

940 Emma: [No. And it’s not systemic.

941 R: So it doesn't always reflect your competence at that point.

942 George: [Absolutely.]

943 Emma: Yes. And it doesn't necessarily show progress either, whereas if you did it
944 like (.) I don't know, in a different way, you might [overspeaking].

945 George: [It sometimes feels a little bit…

946 Charlotte: Because if you've got your <u>first tape</u> and then your second tape
947 hopefully, your marks are going to improve

The extract provides further critique of the measure as "not reflective" (935) of where students perceived their competence to be. Emma responds with a direct response and challenges the measure as "not systemic" (940) reiterating the group views in extract 5 as systemic "real life" (530) as opposed to "fake" and "pure" (531).

The students talk over and interrupt one another within this extract indicating an increased need to share their perspective. Emma questions whether the SPS allows for progression of competence to be measured (943) tentatively suggesting a "different way" (944) might be helpful.

Extract 8 follows a discussion with a group of supervisors regarding the marking of a student's session. As the discussion progresses Stuart introduces the concept of standardisation, which is a way of making something more objective (Ratner, 2002), this contrasts to the systemic norm of social constructionist theoretical stance which would hold subjectivity central (Tseliou & Borcsa, 2018; extract 8).

Extract 8: FG 2 supervisor

Stuart: one of the things that's coming up for me is this question about standardisation and research is about standardisation and trying to get the measure standardised and the problem is I don't think it can be standardised ((laughs)) because what we're saying is each of us has different perspectives and it's those perspectives on the students competency the difference in the perspectives is what matters their difference from our difference from the supervisors difference from the university's difference

Stuart's repetitive use of the word "difference" and "perspective" (203-205) reiterates the challenge of measuring competence when considering the subjective values of systemic theory (Burnham, 2018). The difficulty is highlighted through "the problem is" (202) yet Stuart then switches to the use of "I" to make a personal claim, which is potentially contentious demonstrated through subsequent laughter. Stuart's use of language "what we're saying" (203) highlights supervisors constructing a joint position in the group. The extract also evidences the many layers of subjectivity through the "perspectives" of the wider context when measuring competence (204-206).

Being systemic

Building on the previous two discourses, the following section discusses the discourse of *being systemic* and the complexity of this alongside the use of the SPS. Extract 9 is taken midway through a discussion regarding the purpose of the measure in training.

Extract 9: FG 3 Students

Josie: because we are going in with such a broad range that it's really difficult to to (.) keep in your head because you are managing the session and you are actually working with a family with 12 points to kind of guide you when your also trying to think about (.) what type of questions you are asking.

R: It's a lot in your…

Josie: It's a big big big…

Emma: [You are trying to like shoehorn stuff] in because you know you need to submit something that will raise all those points. So if there can be some sessions where you think, from knowing the family, that's been a really good session, I feel like it was systemic and I feel like the family got something out of it, but that doesn't mean it would hit all of those (.)[overspeaking group] and be at the stage that (.) you know the markers would think it would be a pass. So I think there's a bit of a difference in what you think yourself and ˚how you think your own work is progressing˚ and what that maybe shows in some areas.

George: [and I

Emma: It doesn't match.

Charlotte: It holds back a little bit in a way, doesn't it?

Lucy: Yes

George: But I wonder (3) like I think every single point, when you look at it individually (.) I can totally see why it's part of the criteria. I think it's

193 really good to know these are really the skills that we are trying to build
194 you up in, so I think the the bones of it, I think is actually quite good. I
195 think what (.) we're all saying has been marked against it and perhaps
196 using that as a marking tool is what we are finding difficult or what the
197 expectation of that marking criteria is.

This extract evidences how the students collectively construct in the group a position to defend their ability to *be systemic* whilst "managing the session" (172) alongside holding in mind all the elements of the SPS "it's a lot" (176). An important bit of talk in the extract highlights systemic practice being a felt quality, "I feel like it was systemic" (181). The complexity of the discourse of *being systemic*, whilst "trying to like shoehorn stuff in" (line 178) from the SPS is discussed. Emma shares this dilemma (184-186) using "so" as a discourse marker to connect this idea of her perceived competence and the observed competence. The students' discomfort is demonstrated through a mismatch between what the students view as *being systemic* and what they feel the SPS measures, although this might not be an incompatibility this is how it is potentially being perceived. Extract 10 is taken from further on in the discussion.

Extract 10: FG3 Students

293 George: I think if there's a deadline coming up, I'm very conscious of it and I'm very
294 much like, right, okay, have you done…? So (.) for example, was it convening
295 the session? Then have you done the agenda ((laughs)), have you done
296 session [overspeaking], much clearer than in other sessions where I'm not
297 necessarily thinking it's going to be one I'll submit, I'm a bit more "go with the
298 flow".

299 Charlotte: [Yeah, yeah.

300 Emma: So actually, it feels more systemic because it's more about what the
301 family are bringing, [yeah] it's not me going I've got to get all these points.

The students' discuss the awareness they have of the measure (293-298) which might distract from their systemic values and norms of being able to "go with the flow" (298). Here George positions himself alongside a systemic identity norm which responds to what the family brings to the session (Jones, 2003). This is agreed by the students (299-301). They go on to reiterate how the measure "distracts a little bit from" (308) the notion of following the lead of the family (Extract 11).

Extract 11: FG3 Students

307 Charlotte: ↑There's a lot of pressure, isn't there, when you're in them sessions
308 with families (.) I agree it distracts a little bit from…[yeah

309 Emma: Yeah], from just going with the flow.

310 George: [Yeah].

311 Emma: Your skill's a bit more authentic.

The group continue to support this notion of the SPS potentially restricting their ability to be systemic, go "with the flow" (309) or be "authentic" (311). The extract evidences further group referencing to jointly construct their position through seeking agreement from peers ("isn't there", 307).

As the discussion within the group continues Charlotte positions the discomfort of measuring competence as an ethical issue, "I kind of think there is a sort of ethics type of argument around are we sending a session down a certain

route in order to meet a competency?" (962-964). Charlotte tentatively invites a new position "I kind of think" to the group broadening the context of the implications of the use of the SPS in potential influencing the direction of the session when trying to hold the family in mind (Burnham, 2018).

Discussion

The study aimed to explore whether students and supervisors viewed the SPS as an appropriate way to assess systemic competence in training. The analysis focused on how discourses were constructed regarding competence within focus groups in the context of systemic training. A DA approach was used and three dominant discourses were evidenced within the student and supervisor focus groups: *feedback as valuable, measuring competence* and *being systemic*.

The analysis showed students and supervisors viewed the SPS as a valuable and useful measure of systemic competence however some ambivalence was apparent. The SPS was perceived to broaden perspectives, inviting both the students and supervisors to view the sessions from a different perspective (Anderson & Swim, 1995; O'Donovan, 2015). Discomfort with the broader concept of measuring competence was evidenced particularly when students felt feedback was not grounded within the wider systemic context (Simon, 2010). For example, students shared the importance of receiving feedback within the context of the supervisory relationship and similarly supervisors discussed the importance of discussing feedback in supervision sessions. The discourse within the present study suggested the SPS process, as currently experienced lacked this systemic concept of a circular feedback loop that may have enabled a greater understanding of the feedback provided from the SPS (Jones, 2003; Scaife, 2003).

Anderson and Swim (1995) refer to systemic learning in supervision as interactional, where new knowledge and competence evolves through dialogue and relational reflexivity. Therefore this lack of circularity may have acted as a potential barrier in an opportunity to collaboratively develop a shared understanding of student

competence. Some students within this study reported viewing the process as a 'tick-box' exercise that was not fully utilised within the supervisory context. The process of learning is central to systemic supervision (Burnham, 2018). Schon's (1987) theory of reflection on and in action are pertinent in considering the role a measure such as the SPS could have in facilitating reflexivity within supervision. The impact of power dynamics within a supervisory relationship however may impact the opportunities to be circular and collaborative within supervision sessions.

Another tension that arose within the focus group talk regarded the challenge of maintaining values of systemic practice whilst holding in mind the 12 competencies of the SPS (Burnham, 2018; Moran, 2017). Within the discourse of *being systemic* students shared the difficulties of being authentic and reflexive in the moment with clients, feeling they were unable to "go with the flow". This was raised as a potential ethical issue within a student discussion as to whether it was appropriate for the students' perception of the SPS to influence the direction of the session when trying to hold the family in mind (Burnham, 2018). Nel (2006) had found students were presented with dilemmas throughout their training to re-evaluate their professional identities and roles. Although this was not an explicit focus, many of the participants were experienced practitioners training in additional systemic practice and therefore the discomfort could be a reflection of the re-evaluation of their identities and competence as practitioners.

The research question focused the analysis on how the discourses regarding competence were constructed within the context of systemic training. From a theoretical social constructionist position the use of DA in this study enabled a greater understanding of the role of language, which as discussed previously is pertinent to systemic context (Georgaca & Avdi, 2012; Tickle & Rennoldson, 2016).

There was evidence across the five levels of DA (Appendix J, Georgaca & Avdi, 2012), with some more explicit than others (level 2, language as functional and level 3, positioning). Throughout the analyses there was evidence of joint positioning (level 3). The groups often positioned themselves through the use of collective pronouns or through explicitly agreeing with the discourse rarely dissenting from the dominant discourse. In line with systemic practice this illustrates the collaborative social constructionist perspective where a shared understanding is developed (Anderson & Swim, 1995; Burnham, 2018). This could also be a reflection of the roles and expectations of being within a training group as discussed in the limitations of the study.

Tentative talk and rhetoric questions were also prevalent in the groups (level 2). This often functioned as a way to invite collaborative group talk or to raise something that may have challenged the dominant group discourse. The concept of subjectivity (level 5) was also alluded to within the discourse of *measuring competence* and *being systemic*, particularly around the interpretation of the SPS feedback. The complexities of subjectivity and competence would be interesting to explore further in the context of systemic practice.

Researcher Reflexivity

In qualitative analyses it is important to consider reflexively the role and influence of the researcher on the process of data collection and analysis, from a subjective position of potential bias (Jorgensen & Phillips, 2002; Willig, 2014). The epistemological position adopted for this study was social constructionism and therefore it is important to consider the researchers role in the construction of the group data (Georgaca & Avdi, 2012; Willig, 2014).

I was aware I too am in a “student” position as a trainee clinical psychologist and have used competence scales throughout my clinical training, experiencing them both positively and negatively. This therefore will have influenced how the researcher constructed meaning and assumptions from the discourses constructed. During clinical training, I have been taught systemic competencies and at the time of the research I worked alongside a family psychotherapist. Therefore, I may have focused on particular aspects of discourse that I related to and others may have been overlooked. By attending the DA group and through supervision I had opportunities to discuss the findings and broaden my own perspectives on the data.

Strengths and Limitations

There is limited research on the SPS and systemic competence scales more broadly (Butler et al., 2018). The present study offered a reflective space for the students and supervisors to discuss the SPS and the idea of competence measures more broadly. DA allowed for a broader understanding of the SPS through the views of the peer group context, which is less possible from other qualitative methodologies. The advantage of a shared theoretical social constructionist approach between DA and systemic practice (Tseliou & Borcsa, 2018) enabled a focus on the construction and subjectivity of language and meaning used within the focus groups.

As established training and supervision groups, participants might not have felt able to disagree with the dominant group talk potentially evidenced by a lack of dissent within the groups (Smithson, 2000). Collaboration is a consequence of the formation of groups and the perceived need to work systemically in trainee groups

which could be a limitation of the study design (Smithson, 2018). Individual interviews may have mitigated this.

Recruitment to the study was a challenge. Focus groups were held at two of the five sites approached. The study was reliant on group members' engagement which may have been influenced by power dynamics and hierarchies within the groups or the training context, where participants felt obliged to take part. Patterns were discussed across the focus groups in an attempt to minimise bias. However, the type of analysis conducted is inherently recognised to limit the generalisability of the findings; the implications of the study are of potential relevance however to a broader clinical audience.

Implications for Practice

The SPS is already widely used on SFP courses across the UK (Butler et al., 2018). A primary motivator for the current study were the implications of the SPS in clinical training for students and supervisors. Within the current healthcare climate accountability of outcomes for the service and client are key (NHS England, 2019), with an ethical imperative that patients receive interventions from competent practitioners. The need for valid measures of competence is therefore crucial. The SPS could also provide outcomes to commissioners and funders regarding the fidelity of the training courses and student systemic competence.

Through group talk, the discourse of *feedback as valuable* highlighted how competence scales such as the SPS need to be used in practice in a meaningful way in order for the feedback to be helpful. Both students and supervisors recognised the need for a joined up collaborative process echoed in this study through the discussions of the systemic feedback loop. This supports the developers'

view of the SPS to be “used in dialogue with the supervisor” (Butler et al., 2018, p 5). Further there are implications on how training courses introduce competence measures like the SPS highlighting the potential usefulness of them whilst recognising the inherent limitations of these ‘moment in time’ measurements.

There are potential wider practice implications for the SPS to be used on other clinical training courses such as the Doctorate of Clinical Psychology. As Butler et al. (2018) allude to in their paper, there is the potential that similar to the CTS-R (Blackburn, et al., 2017) which is used in feedback for clinical psychology trainees CBT training, the SPS could be an alternative for systemic teaching. Additionally there are wider implications for the development of training standards within the association for family therapy and the guidance given regarding the use of the SPS in systemic practice both within the current CYP-IAPT but also in on-going systemic training (Butler et al., 2018).

Conclusion

The study contributes to a growing body of research on competence-based measures used in clinical training (Butler et al., 2018; Tweed et al., 2010). DA of five focus groups was conducted with students and supervisors who use the SPS within systemic training. Discourses highlighted feedback from the SPS as valuable particularly when grounded within a systemic context. In line with systemic values, the importance was placed on the circularity of feedback within a collaborative supervisory relationship.

The study highlighted potential clinical and practice implications of the SPS within systemic training but also more broadly in other clinical courses. It raises

questions regarding how competence scales like the SPS can be used in a meaningful way for students and supervisors.

References

Anderson, H., & Swim, S. (1995). Supervision as collaborative conversation: Connecting the voices of supervisor and supervisee. *Journal of systemic therapies*, *14*, 1-13.

Avdi, E. (2005). Negotiating a pathological identity in the clinical dialogue: Discourse analysis of a family therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *78*, 493-511.

Bernard, J.M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Upper Saddle River, NJ: Pearson Education.

Blackburn, I. M., James, I.A., Milne, D.L., Baker, C., Standart, S., Garland, A., & Reichelt, K. (2001). The revised cognitive therapy scale (CTS-R): Psychometric properties. *Behavioural and Cognitive Psychotherapy*. *29*, 431-446.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *Journal of family therapy*,*27*, 237-262.

Burnham, J. (2018). Creating reflexive relationships between practices of systemic supervision and theories of learning and education. In Burck, C. & Daniel, G. (Eds), *Mirrors and Reflections* (pp. 49-78). Routledge.

Butler, C. A., Lask, J., Sheils, L., Crossley, J., Joscelyne, T., & Pote, H. (2018). Measuring competence in systemic practice: development of the 'systemic family practice – systemic competency scale' (SCS). *Journal of Family Therapy*, *0*, 1-21.

Bronfenbrenner, U. (1979).*The ecology of human development*. Harvard university press.

Clinical Outcome in Routine Evaluations (CORE) (2017). Competence frameworks for the delivery of effective psychological intervention. Retrieved from http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the theory of social behaviour*,*20*, 43-63.

Donohue, W. A. & Diez, M. (1985). Directive use in negotiation interaction. *Communication* Monographs, *52*, 305-318.

DuBois, J. W. (2007). The stance triangle. In R. Englebretson (Ed.), *Stancetaking in discourse: Subjectivity, evaluation, interaction* (pp. 139-182). Amsterdam: Benjamins.

Duggleby, W. (2005). What about focus group interaction data? *Qualitative Health Research*, *15,* 832-840.

Epstein, R.M., &Hundert, E.M. (2002). Defining and accessing professional competence. *Journal of the American Medical Association*, *287*, 226-235.

Gallichan, D., & Mitchell, A. (2008). Making the case for in vivo assessments of clinical competence. In *Clinical Psychology Forum-new series* (Vol. 184, pp. 18-22). Leicester, British Psychological Society.

Gee, J. P. (2014). *An introduction to discourse analysis*, 4th Ed. Routledge: Oxon.

Georgaca, E., & Avdi, E. (2012). Discourse analysis. In Harper, D., & Thompson, A.R. (Eds.) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 147-162).London: Wiley and Sons.

Hedges, F. (2005). Overview of systemic therapy: theory/practice. In Frosh S. (Eds), *An introduction of systemic therapy with individuals: A social contructionist approach* (pp. 8-26). London: Red Globe.

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed.), *Conversation analysis: Studies from the first generation* (pp. 13–31). Amsterdam: Stuart Benjamins.

Jones, E. (2003). Reflections under the lens: observations of a systemic therapist on the experience of participation and scrutiny in a research project. *Journal of Family Therapy*, *25*, 347-356.

Jørgensen, M. W., & Phillips, L. J. (2002).*Discourse analysis as theory and method*. Sage.

Ladany, N., Mori, Y., & Mehr, K. E. (2013). Effective and ineffective supervision. *The Counseling Psychologist*, *41*, 28-47.

Moran, P. (2017) Selecting self-report outcome measures for use in family and systemic therapy. *Journal of Family Therapy*, 39, 41-46.

Nel, P. W. (2006). Trainee perspectives on their family therapy training. *Journal of Family Therapy*, *28*, 307-328.

NHS England. (2019). The NHS Long Term Plan. Retrieved from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

O'Donovan, A., Halford, W. K., & Walters, B. (2011). Towards best practice supervision of clinical psychology trainees. *The Australian Psychological Society*, *46*, 101-112.

Potter, J. & Wiggins, S. (2007). Discursive psychology. In C. Willig & W. Stainton-Rogers (Eds.), *Handbook of qualitative research in psychology* (pp. 73-90). London: Sage.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.

QSR. (2012). *NVivo qualitative data analysis software*: QSR International Pty Ltd.

Ratner, C. (2002). Subjectivity and objectivity in qualitative methodology. In *Forum* (Vol. 3, No. 3). Berlin, Qualitative Social Research.

Roy-Chowdhury, S. (2006). How is the therapeutic relationship talked into being?. *Journal of Family Therapy*, *28*, 153-174.

Roy-Chowdhry, S. (2010). Is there a place for individual subjectivity within a social constructionist epistemology? *Journal of Family Therapy*, *32*, 342-357.

Sargeant, J.M., Mann, K.V., van der Vleuten, C. P., & Metsemakers, J. F. (2009). Reflection: a link between receiving and using assessment feedback. *Advances in Health Science Education*. *14*, 399-410.

Scaife, J. (2003). *Supervision in the mental health professions: A practitioner's guide*. London: Routledge.

Schön, D. A. (1987). *Educating the reflective practitioner*. New York: Basic Books.

Simon, G. (2010). Self-supervision, surveillance and transgression. *Journal of Family Therapy*, *32*, 308-325.

Smithson, J. (2000). Using and analysing focus groups: Limitations and possibilities. *International Journal of Social Research Methodology, 3*, 103-119.

Smithson, J. (2018), Group Interviews. In *Encyclopaedia of Social Research Methods*, London, Sage. Forthcoming.

Sutherland, O., Fine, M., & Ashbourne, L. (2012). Core competencies in social constructionist supervision? *Journal of marital and family therapy*, *39*, 373-387.

Stratton, P., Reibstein, J., Lask, J., Singh, R., & Asen, E. (2011). Competences and occupational standards for systemic family and couples therapy. *Journal of Family Therapy*, *22*, 123-143.

Tickle, A., & Rennoldson, M. (2016). Systemic family therapy. In: D. Dawson and N. Moghaddam, eds.,*Formulation in action. Applying psychological theory to clinical practice.* Warsaw: De Gruyter Open, pp. 123-141.

Tseliou, E., & Borcsa, M. (2018). Discursive methodologies for couple and family therapy research: Editorial to special section. *Journal of marital and family therapy*, *44*, 375-385.

Tweed, A., Grabner, R., & Wang, M. (2010). Assessing trainee clinical psychologists' competence. *Psychology Learning & Teaching*, 9, 50-60.

Willig, C. (2014). Discourses and discourse analysis. In U. Flick (Ed), *The SAGE handbook of qualitative data analysis* (341-353). London: Sage.

Wilkinson, S. (2008). Qualitative Psychology. In Smith, J.S. (Ed) *A practical guide to research methods*. 2nd Edition. London:Sage.

Wilson, H. M. N., Davies, J. S., & Weatherhead, S. (2016). Trainee therapists' experiences of supervision during training: A meta-synthesis. *Clinical Psychology and Psychotherapy*, *23*, 340-351.

Appendices

Appendix A: SPS measure (Butler et al., 2018)

Appendix B: Ethics documentation

Appendix C: Information Sheet (Student)

Appendix D: Information Sheet (Supervisor)

Appendix E: Consent Form (Student and Supervisor)

Appendix F: Demographic questionnaire

Appendix G: Focus Group Topic guide (both supervisor and student)

Appendix H: Jefferson Transcription Conventions

Appendix I: Seven Steps in Good Quality Discourse Analysis (Potter & Wiggins, 2007)

Appendix J: Dissemination statement

Appendix K: Copy of instructions for author – Journal of Family Therapy

Appendix A

SPS measure (Butler et al., 2018)

Purpose

This scale has been devised to provide a structure for the assessment of Systemic Family Practice (SFP) skills. It is designed to evaluate a whole session but in addition can be used as a training and supervision tool and the focus may then be on particular areas of competence.

Rating the scale

The seven-point scale (i.e. a 0-6 Likert scale) extends from (0) where the practitioner does not demonstrate that skill to (6) where a high level of skill is demonstrated. Please refer to the competence level examples found below. These examples are intended to be used as useful guidelines only. They are not meant to be used as prescriptive scoring criteria, rather providing both illustrative anchor points and guides. There is inevitable overlap of the competencies so some aspects will be doubly rated. For example, circular questions may be rated as a change technique and as an aspect of systemic reframing.

Adjusting the scale to the challenges presented by families

The particular therapeutic challenges of the family, and the requirement for therapeutic intervention at a particular time, should be taken into account and individual items scored in relation to the therapeutic needs of the family. If the marker thinks it is appropriate that an item is not covered at all, then it should be rated at 3. If it is covered minimally, but appropriately, it can be scored higher. For example, it may be appropriate to hold back from exploring diversity until a later session. It

would be expected that for most sessions all dimensions would be covered.

Interrelatedness of Items

All of the Items are of course related and, as with all assessment, there is a distinction being made that does not completely hold.

This scale has been tested for reliability and validity and is based on the well-established Cognitive Therapy Scale – Revised (CTS-R) used in rating competence in Cognitive Behavioural Therapy training and has been informed by well-established training practice within the field of Family Therapy and Systemic Practice. It is informed by the Competency map for Systemic Family Therapy (Roth and Pilling 2007). It is based on the Dreyfus system, which keeps the highest levels of attainment for very high levels of practice.

Example of the scoring layout

Mark with an 'X' on the horizontal line, the level to which you think the practitioner has fulfilled the core function. Please use whole and half numbers. The descriptive features below are designed to guide your rating

N.B. When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy, perceived family difficulty and fit with the particular family being seen.

Competence Level Examples

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0 1 2 3 4 5 6

0.	Inappropriate absence of feature or highly inappropriate use
1.	Very little evidence that feature has been considered and addressed, or has been done in an inappropriate way
2.	Evidence of some competency but examples of unhelpful practice and general lack of consistency.
3.	Competent, but some problems and/or inconsistencies
4.	Competent with, minor problems and/or inconsistencies
5.	Very competent, minimal problems and/or inconsistencies
6.	Excellent performance, even in the face of high levels of complexity and challenge from family members

The benchmark for a 6 is a level of practice at the highest level expected from a successful Systemic Family Practitioner trained to intermediate level. It is expected that most practitioners will score a 3/4 with fewer scoring at the higher and lower ends of the scale. An average score of 3 should be considered the minimum for students reaching the level of clinical competence required to successfully complete a CYP-IAPT Systemic Family Practice course (Intermediate level). It follows that in the early stages practitioners may score at a low level as this scale is specifically for Systemic Practice Skills and these may be unfamiliar. It is important to explain this in order to avoid discouragement.

Please note this is a measure relating to one therapist's activity. It does not measure the involvement of a co-therapist, a reflecting team or an in-room supervisor. There

is a free text box at the end of the scale if you wish to comment on the co-therapist, reflecting team or supervisor.

Item 1: Interpersonal Effectiveness and Development of Therapeutic Alliance

Key features: This dimension refers to some of the key elements in the creation of a sound therapeutic alliance - warmth, empathy, genuineness, understanding and a non-judgmental stance. It involves verbal and non-verbal skills such as 'joining', listening and creating a warm inviting atmosphere for all family members, taking account of developmental level, age and position in the family. It includes appropriate adherence to boundaries and use of self. A key element is the communication of these 'positions' to the family members.

0.	Practitioner's manner and interventions contribute to general disengagement or to an atmosphere of distrust or hostility.
1.	Difficulty in showing appropriate warmth, empathy and understanding in relation to family members, or lack of appropriate boundaries.
2.	Difficulty in demonstrating respect for the views of every family member although there is evidence of some warmth and empathy. Inconsistency in responding to the feedback from family members
3.	Good understanding of explicit meanings of communications from all family members, resulting in a good degree of trust developing, some evidence of inconsistencies in sustaining relationships with all family members. Good attention to different developmental stages of the children and young people.
4.	Ability to understand the implicit, as well as the explicit meanings of the communications and demonstrates it in his/her manner. Minor problems evident (e.g. inconsistencies or greater struggle to connect with particular family members).
5.	Demonstration of very good interpersonal effectiveness with all family members. Everything is done to help family members feel safe and confident and to engage in a sound therapeutic alliance. Minimal problems but generally therapeutic alliance

	issues are not due to ability of practitioner. Creativity in engaging younger children and adolescents
6.	Highly interpersonally effective, even in the face of difficulties. Shows creativity in responses to different family members.

Qualitative feedback from supervisor related to Item 1:

Qualitative feedback from supervisor related to Item 2:

Item 2: Convening and managing the session

Key features: This includes five main elements and practitioners are expected -

1. To begin the session in a way that is inclusive of all family members, ensuring the involvement of all present including small children. This includes appropriate use of toys and drawing materials.
2. To collaboratively agree a clear focus and to hold onto that focus through the session allowing for useful diversions when necessary.
3. To manage the session so that it has a beginning, middle and end, within the time constraints set, and managing essential administrative tasks sensitively within the allotted time.
4. Ensure that discussions are appropriate for the stage of the work, client needs and point in the session. Where appropriate making good connections with past sessions and future sessions.
5. Pacing the session to fit the needs of family members.

0.	Poor beginning to the session and no attempt at engaging or agenda setting. Session pace does not fit the needs of family members.
1.	Little time given to convening, poor time management and lack of focus, or the application of an over rigid agenda. Problems with pacing.
2.	Time given to convening but may not include all family members. Lack of collaboration in agenda setting but some attempts to create focus in the session. Some problems with time management.
3.	Good beginning to session and appropriate agenda but may be a lack of consistency in focus and pacing of session. May include some problems with time management, the inclusion of all family members, or ending the session.
4.	Good convening, appropriate agenda, minor difficulties in focus and time management. Good pacing of the session.
5.	Good convening and appropriate agenda set with good collaboration and focus throughout the session. All administrative tasks covered and good sense of beginning, middle and end to the session. Focus and flexibility are used appropriately.
6.	Excellent collaborative agenda set, and reviewed despite challenges in the therapeutic relationship. Ability to hold to the shared goals whilst also addressing other issues that may arise and appropriately need to be addressed. All administrative tasks covered with sufficient time allowed for discussion. Session brought to an appropriate ending.

Item 3: Collaboration

Key features: Working collaboratively is central to a systemic approach. The aim is for all family members to be active in the session and involved in decisions about goals and the development of the work. There must be clear evidence of productive teamwork, with the practitioner skilfully encouraging all family members to participate fully (e.g. through questioning techniques, shared problem solving and decision making). The expertise and knowledge of family members should be identified, acknowledged and used, and the practitioner should aim to use their own expertise

without inflexibly maintaining an expert position. This will include sharing of information and inviting different kinds of feedback. Another element is the ability to use tentative language that invites a co-construction of ideas.

0.	Family members are actively prevented or discouraged from being collaborative.
1.	The practitioner is too controlling, dominating, or passive and does not actively invite different forms of collaboration.
2.	There are occasional attempts at collaboration, but with little consistency and some family members may be excluded from this process.
3.	Teamwork evident, but some problems with collaboration (e.g. not enough time allowed for the family member to reflect and participate actively). Some use of tentative language as a tool to invite discussion.
4.	Effective collaboration is evident, but not entirely consistent. The practitioner checks out the family members' experience of the session and is able to adapt the session in response to feedback. Consistent use of tentative language.
5.	Effective collaboration evident throughout most of the session, both in terms of verbal content and sharing of information. Good attention paid to style and culture of family and the impact of this on the collaborative process**.** Flexibility in ways of encouraging collaboration and regular use of 'checking out' with the family. (relational reflexivity)
6.	Effective collaboration throughout the session (all family members), and creativity and skill in responding to any challenges to this process.

Qualitative feedback from supervisor related to Item 3:

Item 4: Conveying a systemic view of family life, wider context and relationship of family to the problem

Key features: A key element in SFP is to help family members understand difficulties relationally and in the context of family and other relationships. This includes ideas such as circularity, family beliefs, behaviour and relationship patterns, narratives and wider system involvement. This systemic reframing is an essential basis for SFP interventions. This is often achieved through good use of circular and other questions together with reframing techniques and the process of the inclusion of multiple family members.

0.	Practitioner conveys no evidence of systemic understanding during the session.
1.	Some attempts to introduce systemic understanding but clumsy, and with no attempt to take into account the beliefs of family members.
2	The conveying of an over rigid and narrow systemic explanation which may blame the family, Little attempt to take into account beliefs of family members. Limited attention to wider systems.
3	Ability to apply systemic reframes and descriptions but with limited time taken to obtain feedback from family members or explore different ideas. Ability to use questions and track a circular sequence of interaction but may be inconsistencies.
4.	Good ability to reframe systemically in a way that takes into account history over time, developmental issues and effect of problem on the family. Good use of questions to elicit systemic connections.
5.	Consistent use of systemic ideas throughout the session adapted for all family members with good time given for discussion and feedback. Excellent use of questions to elicit systemic connections.
6.	Creativity in conveying systemic ideas including the use of non-verbal techniques and questions. Ability to manage challenges to a systemic perspective in a way that maintains a good therapeutic alliance.

Qualitative feedback from supervisor related to Item 4:

Item 5: Conceptual Integration

Key features: A flexible conceptual map or formulation is necessary to structure the work and create coherence. This dimension refers both to the practitioner's own conceptualisation, which should manifest itself in a coherent approach within the session, and the ability to convey these ideas to family members. It is expected that these maps will increase in complexity as the practitioner gains experience of different models and approaches.

0.	No evidence of conceptual map or formulation.
1.	Occasional evidence of conceptual thinking but no coherence or consistency in the session.
2.	Some evidence of conceptual thinking but not carried through, or linked well enough to formulation.
3.	Use of conceptual thinking evident in the session and informs most interventions. Some communication of ideas with family members. However, there may be inconsistencies or lapses.
4.	Good conceptual thinking clearly informing interventions but limited to a narrow range of ideas with some lack of skill in involving all family members in the thinking.
5.	Complex conceptualisations informing the session and good skills in taking account of the thinking and positions of family members when introducing the ideas. Clear connections between interventions, formulation and systemic theories.
6.	Good conceptualisations, open to revision and review and communicated in a collaborative way to family members. Coherent session and may include sharing of research findings or using a range of verbal and non-verbal ways of communicating ideas.

Qualitative feedback from supervisor related to Item 5:

Item 6: Use of questioning

Key features: The use of questioning is a key element in systemic work and in most interventions. It requires a stance of openness and curiosity as well as an ability to use questions in a strategic way to enhance observation and change thinking**.** Hypothesising is important as a guide to questioning and it also involves the ability to hold a position of uncertainty.

0.	Very little evidence of purposeful questioning.
1.	Some questions but tend to be closed or focused on gathering specific information and have an interrogatory quality.
2.	Use of some circular and other types of questions but with no evidence of a guiding hypothesis. No clear use of family feedback to guide direction of questioning.
3.	Use of purposeful questions organised around an idea or hypothesis identified in the on-going formulation and evidence of working from feedback.
4.	Good circular and other questions used for interventions as well as information gathering. Good attention to feedback and style of questioning differentiated well to fit with needs of different family members and purpose.
5.	Excellent range of questioning organised to support a range of interventions and designed well to fit with different family members. Evidence that they are making a difference to family thinking and functioning.
6.	Good use of questioning carefully following feedback and contributing continuously to the therapeutic plan, maintained even when there are difficulties and fully involving all family members.

Qualitative feedback from supervisor related to Item 6:

Item 7: Feedback

Key features: Feedback is used in a number of ways and includes reframing. It is the ability to provide a response to session content and process, that is helpful to family members. It is used to enhance interventions such as externalisation (unique outcomes) and solution focused approaches (exceptions) and to highlight and encourage more positive behaviour and relationships (scaffolding). It includes positive feedback and positive connotation. This is different from the feeding back to a family what has been said to the therapist. This latter intervention is a key part of demonstrating listening skills and empathy, especially evident in the initial stages of the work and is rated under interpersonal skills. It is also different from the important skill of working in response to feedback from the family. This is covered in a number of items including questioning interventions.

0.	Absence of feedback.
1.	Feedback only given if requested and is not purposeful. The effect on family members is not sufficiently considered.
2.	Some feedback but mostly when summing up or giving more formal feedback such as at the end of the session.
3.	Some evidence of taking opportunities to feed back and support positive aspects but not consistent and not always taking account of the way in which feedback may be experienced.
4.	Good use of feedback when associated with a particular intervention (e.g. supporting changes in behaviour or relationships) but less evident throughout the session. Good account taken of effect on all family members in the session.
5.	Good use of feedback to support a variety of interventions throughout the session and which may include practitioner's own reactions and experiences. Good pacing.
6.	Excellent use of feedback to all family members even in the face of difficulties. Good flexibility in adapting to family style.

Qualitative feedback from supervisor related to Item 7:

Item 8: Intervening in process during the session

Key features: This requires an understanding of the process between family members (patterns of interaction), and also the ability to intervene directly in that process through active questioning, communication work, enactment, role play, coaching. It includes active interventions to help family members experience different positions in the family and therefore encouraging empathy. It requires a leadership approach that engages and involves family members in the process. It needs to be based on a systemic understanding and a good therapeutic alliance.

0.	No evident awareness of process as a focus for intervention or comment.
1.	Some awareness of process but no connections made between content and process, or attempt to address process in the session.
2.	Some awareness of process but interventions are not followed through or connected well enough to the session in general.
3.	Evidence awareness of process and attempts in the session to help family make changes. Simple interventions, such as slowing the process and taking turns in communicating, and helping parental alliance will be achieved.
4.	Good use of process observations and skills in discussions and direct interventions. Good attention paid to level of engagement and “fit” for all family members.
5.	A range of ways of intervening in process including enactment, work to strengthen parent subsystem and different ways of working with communications. Will stay focused on the intervention.
6.	Creativity in working with process adapted to suit different family members even when particular challenges to carrying out the interventions. Maintenance of good therapeutic relationship with all family members and appropriate use of humour and self disclosure.

Qualitative feedback from supervisor related to Item 8:

Item 9: Working with power and difference

Key features: This includes four main elements.

1. Working to reveal differences between family members and appropriately working with that difference.
2. Ability to hold and respect different positions and perspectives within the family.
3. Using an understanding of power differentials between family members, practitioner and the family, and within different wider contexts to inform interventions
4. Paying attention to differences such as ability, gender, race, sexuality, spiritual beliefs, age, etc. and the way in which these inform behaviour, relationships and beliefs; exploring and taking account of these in the work.
5. Taking an ethical stance to ensure protection of vulnerable family members. This includes attention to safeguarding.

0.	No attention to difference.
1.	Some awareness of difference but not explored.
2.	Some areas of difference noted but no effort made to appropriately explore these. No exploration of cultural and power differences in the wider community.
3.	Some attention to difference and exploration of the meaning of this for family members. Ability to raise concerns of safety and ask about power and difference issues such as class, economic status, culture, religion and ethnicity.
4.	Good exploration of difference and its meanings, and attention to more subtle power differentials within the family, therapy and wider contexts, including all family members. Appropriate exploration of any safeguarding issues in a way that optimises the possibility of collaboration and protects vulnerable members of the family.
5.	Taking account of difference throughout the session and making it an ongoing part of the understanding of the family. Use of curiosity to explore difference. Use of questioning to explore difference and power issues between therapy (team, agency) and the family. (relational reflexivity)
6.	Excellent attention to difference and good skills in talking about it even in difficult circumstances. Using creative ways to help family members explore their differences further in a positive and productive way.

Qualitative feedback from supervisor related to Item 9:

Item 10: Exploring and managing emotions in sessions

Key features: Working with the connections between behaviour, relationships, beliefs and emotions is a key skill. Practitioners need to be able to talk about emotions but contain them safely in a family session. They also have to ensure that family members feel understood and can develop strategies to manage their own emotions

0.	No eliciting of emotions or ability to respond appropriately to emotional content of session.
1.	Occasional eliciting of emotion but limited to certain family members or responded to in an unhelpful way.
2.	Some questioning about emotions and appropriate reaction and some notice of emotional response in session but inconsistent or limited to particular emotions or family members.
3.	Ability to talk about emotions that arise in session discussions, connect them to relationships and behaviour. Ability to tolerate and contain emotions in a helpful way . The discussions are superficial or not carried through.
4.	Ability to rigorously explore emotions, even those which are more difficult for both practitioner and family members. Attends to responses of all family members in the room. Begins to work with strategies to manage emotions.
5.	Acknowledges and discusses a range of emotions including happiness, conflict, anger and sadness. Observes the atmosphere in the room and subtle signs of emotional atmosphere. Helps all family members understand and explore emotional aspects of relationship taking account of history and context.
6	Works positively with a range of emotions in a number of different ways even when the emotional atmosphere in the session is challenging and some family members may want to stifle the discussion. Maintaining a good therapeutic relationship.

Qualitative feedback from supervisor related to Item 10:

Item 11: Use of Change techniques

Key features: Practitioner skilfully uses appropriate interventions in line with the formulation. There is some overlap with a number of other items, and activities may be rated more than once. This item focuses on the ability of the practitioner to use a range of interventions to help initiate and support change.

Three features need to be considered:

1. Appropriateness of interventions in relation to the formulation and evidence base.

2. Skill in the application of the methods.

3. The way the intervention fits for the family members – paying attention to pace, developmental level, language, therapeutic alliance and acceptability of intervention.

0.	Practitioner fails to use, appropriate interventions, or uses interventions that are not appropriate or connected to the needs of the family.
1.	Practitioner initiates interventions but they are poorly executed and/or lack sensitivity to needs of the family at that particular time.
2.	Practitioner uses some appropriate interventions but not followed through or not well enough connected to needs of family.
3.	Practitioner applies a number of methods in competent ways, although some problems may be evident (e.g. the interventions are

	incomplete or poorly presented to the family).
4.	Practitioner applies a range of methods with skill and flexibility, enabling family members to develop new perspectives and make changes Minor problems evident.
5.	Practitioner systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.
6.	Excellent range of interventions, skilfully carried out even in the face of difficulties.

Qualitative feedback from supervisor related to Item 11:

Item 12: Incorporating the outside world

Key features: It is important for practitioners to bring wider systems and networks into their formulation and into interventions. This could include other family members, professional networks or important groups such as community, church, peer group and school. It also involves the identification of pressures and stresses such as poverty, unemployment or discrimination, which are important in understanding difficulties and planning ways of helping.

0.	No inclusion of anyone outside immediate family members in session discussions.
1.	Occasional questions asked about external networks, context and wider family but no follow up or continued reference to these in the session.
2.	Some questioning about external world but little empathy with the experience of family members and little response to issues raised by family members.
3.	Good exploration of wider contexts and some attempts to explore the experience of different family members and to incorporate this into conceptualisation of the difficulties. Identification of important people

	who may be included in session or part of liaison work.
4.	Wider contexts clearly part of thinking throughout the session and good ability to follow up information brought in by family members. Ability to work collaboratively to bring together views of professionals and other networks and to take wider context into account when devising tasks.
5.	Ability to use relationships with wider contexts as a core part of the work. To give tasks that make use of external resources and help family members to identify and work with some of the constraints and opportunities available in the outside world.
6.	Ability to explore different levels of relationship with outside world and continuously monitor, and discuss how these affect family members even when this is difficult and to do so in a way that fits for family and family members.

Qualitative feedback from supervisor related to Item 12:
Where appropriate, please comment on practitioner's ability to effectively make use of supervisory comments and interventions from reflecting team and /or co-therapist

Systemic Family Practice/Systemic Skills Rating Scale

Please see guidance notes

Mark with an 'X' on the horizontal line, using whole and half numbers, the level to which you think the practitioner has fulfilled the core function.

N.B. When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy, perceived family difficulty and fit with the particular family being seen.

1. Interpersonal Effectiveness and Development of Therapeutic Alliance

0 1 2 3 4 5 6

2: Convening and managing the session

0 1 2 3 4 5 6

3. Collaboration

0 1 2 3 4 5 6

4. Conveying a Systemic View

0 1 2 3 4 5 6

5. Conceptual Integration

0 1 2 3 4 5 6

6. Use of Questioning

0 1 2 3 4 5 6

7. Feedback

0 1 2 3 4 5 6

8. Intervening in Process

0 1 2 3 4 5 6

9. Working with Power and difference

0 1 2 3 4 5 6

10. Exploring and managing emotions in sessions

0 1 2 3 4 5 6

11. Use of change techniques

0 1 2 3 4 5 6

12. Incorporating the outside World

0 1 2 3 4 5 6

Final Comments (areas of strength/development)

Appendix B

Demographic questionnaire

SCHOOL OF PSYCHOLOGY

Demographic Questionnaire

Is the systemic family practice- systemic competency scale (SFP-SCS) a helpful measure for students in the development and understanding of their systemic competency?

Version 1 27.10.2017

Thank you for agreeing to complete the following questionnaire. All information collected on the questionnaire will remain anonymous. The questionnaire will ask you to provide some information about yourself. You do not have to provide an answer to the question and data can be withdrawn at any point.

Gender:

Age:

Ethnicity:

Job title:

Length in current position:

Are you currently studying? Yes No N/A (Please circle)

What year of study are you in?

Previous qualifications (please specify):

Appendix C

Focus group topic guide

(Bracketed italics represent amendments for supervisor group)

Introduction – introduce the study, the purpose, procedure. Discuss confidentiality.

Offer opportunities to discuss the research project and any issues that may arise (i.e. withdrawal from the study, confidentiality). Ensure participants have read and understood the information sheet and the consent form is signed by the participant prior to starting the group.

Once people have settled in the group, check with the group whether they know each other, if not start the group with introductions and getting to know one another.

Initial question: "It would be really useful to start by hearing your experiences of receiving feedback from the SPS measure / (*using the SPS)*"

Topics to facilitate group discussion that link to the RQs:

- **Learning:** Can someone talk about how the measure has impacted their learning? Were you surprised? Does it fit with what you think about your skills?
- **Receiving / (*giving)* feedback:** How did you find the process of feedback? Is (*was)* it helpful? What could be improved?
- **Identity:** How does this feedback reflect your identity as practitioners? Does it reflect your competence? *(How does the feedback help students reflect on their identity?)*
- **Impact on clinical practice:** Can you see evidence of change in your practice using the measure? What change? Why? (*reflections on clinical use?)*

Conclusion- Summarise the discussions, thank participants for their time, debrief, and discuss dissemination of results

Appendix D

Jefferson Transcription Conventions

Adapted from Jefferson, 2004

(0.5) Number in brackets indicates a time gap in tenths of a second.

(.) A dot enclosed in brackets indicates a pause in the talk of less than two-tenths of a second.

= 'Equals' sign indicates 'latching' between utterances.

[ ] Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.

(( )) A description enclosed in a double bracket indicates a non-verbal activity.

- A dash indicates the sharp cut-off of the prior sound or word.

: Colons indicate that the speaker has stretched the preceding sound or letter.

(inaudible) Indicates speech that is difficult to make out. Details may also be given with regards to the nature of this speech (eg. shouting).

. A full stop indicates a stopping fall in tone. It does not necessarily indicate the end of a sentence.

↑↓ Pointed arrows indicate a marked falling or rising intonational shift. They are placed immediately before the onset of the shift.

<u>Under</u> Underlined fragments indicate speaker emphasis.

CAPITALS Words in capitals mark a section of speech noticeably louder than that surrounding it.

° ° Degree signs are used to indicate that the talk they encompass is spoken noticeably quieter than the surrounding talk.

Appendix E

University of Exeter Ethical Approval

CLES – Psychology
Psychology
College of Life and Environmental Sciences
University of Exeter
Washington Singer Building
Perry Road
Exeter
EX4 4QG
Web: www.exeter.ac.uk

CLES – Psychology Ethics Committee

Dear Claire Parker

Ethics application - eCLESPsy000478
Is the systemic family practice- systemic competency scale (SFP-SCS) a helpful measure for students in the development and understandi

Your project has been reviewed by the CLES – Psychology Ethics Committee and has received a Favourable opinion.

The Committee has made the following comments about your application:

If you have received a Favourable with conditions, Provisional or unfavourable outcome you are required to re-submit for full review and/or confirm that committee comments have been addressed before you begin your research.

If you have any further queries, please contact your Ethics Officer.

Yours sincerely

Date: 13/03/2018

CLES – Psychology Ethics Committee

Appendix F

Information Sheet (Student)

SCHOOL OF PSYCHOLOGY

Participant Information Sheet

Is the systemic family practice- systemic competency scale (SFP-SCS) a helpful measure for students in the development and understanding of their systemic competency?

Version 2 (03.10.2018)

Please read the information sheet carefully before making a decision about participating in the research. This information sheet provides guidance about what taking part in the study would involve and what will happen to the data collected after the research has been completed. If, after reading this you have any questions please feel free to discuss with the researcher.

Thank you for taking the time to read this.

What is the study about?

The study is interested in understanding more about practitioner's experiences of using the systemic family practice – systemic competence scale (SFP-SCS) and also exploring some of the properties of this measure.

Why are we interested in this?

Government initiatives are focused on improving outcomes for those accessing psychological services. The children and young peoples, improved access to

psychological therapies programme (IAPT) has been developed as part of this long-term plan. Understanding more about the use of measures looking at therapist competence within different therapeutic modalities will help provide evidence towards the quality of therapeutic interventions.

Why have I been invited?

We are inviting all systemic family practitioners who are part of the CYP-IAPT systemic training at the University of Exeter, Kings College London and the University of Manchester to participate in this research.

Do I have to take part?

There is no obligation to take part in the research. If you do decide to take part, you are free to withdraw from the study at any time without giving a reason.

What will I have to do if I choose to take part?

Data from your completed SFP-SCS measures will be used for the analysis. If you do not wish for your SFP-SCS data to be used in this study, please complete the 'Opt-Out Consent form'.

If you choose to take part, you will be invited to participate in a focus group with other systemic practitioners who have been on the training to discuss your experiences of receiving feedback from the SFP-SCS. Groups will be held in Exeter, London and Manchester. This one-off group may last between 40 minutes – 1.5 hours.

What are the possible disadvantages or risks or taking part?

In order to take part in this study you will need to give up some time to participate in the focus group. It is not anticipated that any of the questions asked in this group would raise any concerns however if they do make you feel uncomfortable at any point this can be raised with the researcher during or after the group.

What are the possible benefits of taking part?

The project will help to understand more about the SFP-SCS measure and how it can be best developed for you and other practitioners in clinical practice. The data collected from this study will contribute to a larger body of work that is being conducted on the role of assessing therapist competence in systemic practice.
You will be given £5.00 to thank you for your time in participating in the study.

Will my responses be kept confidential?

Your scores from the SFP-SCS measure will be anonymised and kept confidential. If, however you provide consent for your SFP-SCS scores to be linked to the focus group data, the researcher will anonymise once the data has been linked.
Although the researcher will keep the discussions of the group confidential, it is not possible to guarantee other group members will. Confidentiality will be discussed at the beginning of the group and respect for people's views to remain confidential and anonymous will be explained. All audio data files will be anonymised and stored on a secure university drive only accessible by the researcher, these will be destroyed at the end of the study in July 2019. Any written information will be anonymised and stored in a locked filing cabinet in a secure location and destroyed by the end of the research in July 2019. Participants will be able to remove the data from the study

after the focus group has been completed if they wish to. The transcripts from the focus-groups will be stored securely for a period of 10 years from collection.

What would happen if the researcher were concerned about yours or your client's safety?

If a researcher becomes concerned about your safety or that of your clients, they may need to contact their supervisor to follow up on this to ensure you and your client are safe.

What will happen to the results of this project?

The research team will analyse all the information gathered from the study which will then form part of a research project for the completion of a Doctorate in Clinical Psychology at the University of Exeter. If appropriate the findings may be published in academic journals and presented at conferences. We would also be happy to provide you with information about our findings if you wish to receive them.

What now?

We hope we have answered any questions you may have had about the research. If you would like to take part, please contact the researcher at the email. If you would like your SFP-SCS data to be excluded from the study, please complete the 'Opt-Out Consent form'.

There will be opportunities at the focus group to ask any further questions or please contact us prior to this if required.

Contact for further information

If you have any further questions, please feel free to contact us.

Claire Parker

Email: c.h.parker@exeter.ac.uk

Researchers:

Dr Claire Parker (Trainee Clinical Psychologist)

Supervisors:

Dr Janet Smithson (Senior Lecturer in Psychology)

Dr Jenny Limond (Research Director, Consultant Clinical Psychologist)

This project has been reviewed and approved by University of Exeter

Dr Nick Moberly N.J.Moberly@exeter.ac.uk

Psychology Chair of Ethics, University of Exeter

Appendix G

Information sheet (Supervisor)

SCHOOL OF PSYCHOLOGY

Participant Information Sheet (Supervisor)

Is the systemic family practice- systemic competency scale (SFP-SCS) a helpful measure for students in the development and understanding of their systemic competency?

Version 2 (03.10.2018)

Please read the information sheet carefully before making a decision about participating in the research. This information sheet provides guidance about what taking part in the study would involve and what will happen to the data collected after the research has been completed. If, after reading this you have any questions please feel free to discuss with the researcher.

Thank you for taking the time to read this.

What is the study about?

The study is interested in understanding more about practitioners and supervisors' experiences of using the systemic family practice – systemic competence scale (SFP-SCS) and exploring some of the properties of this measure.

Why are we interested in this?

Government initiatives are focused on improving outcomes for those accessing psychological services. The children and young peoples, improved access to psychological therapies programme (IAPT) has been developed as part of this long-term plan. Understanding more about the use of measures looking at therapist competence within different therapeutic modalities will help provide evidence towards the quality of therapeutic interventions.

Why have I been invited?

We are inviting all supervisors of systemic family practitioners who are part of the CYP-IAPT systemic training at the University of Exeter, Kings College London and University of Manchester to participate in this research.

Do I have to take part?

There is no obligation to take part in the research. If you do decide to take part, you are free to withdraw from the study at any time without giving a reason.

What will I have to do if I choose to take part?

If you choose to take part, you will be invited to participate in a focus group with other supervisors to discuss your experiences of using the SFP-SCS. Groups will be held face-to-face in Exeter, London and Manchester or via skype depending on the groups' wishes. This one-off group may last between 30 minutes to 1 hour. The group will be audio recorded and transcribed verbatim.

What are the possible disadvantages or risks or taking part?

In order to take part in this study you will need to give up some time to participate in the focus group. It is not anticipated that any of the questions asked in this group would raise any concerns however if they do make you feel uncomfortable at any point this can be raised with the researcher during or after the group.

What are the possible benefits of taking part?

The project will help to understand more about the SFP-SCS measure and how it can be best developed for you and other practitioners in clinical practice. The data collected from this study will contribute to a larger body of work that is being conducted on the role of assessing therapist competence in systemic practice.
You will be given £5.00 to thank you for your time in participating in the study.

Will my responses be kept confidential?

Although the researcher will keep the discussions of the group confidential, it is not possible to guarantee other group members will. Confidentiality will be discussed at the beginning of the group and respect for people's views to remain confidential and anonymous will be explained. All audio data files will be anonymised and stored on a secure university drive only accessible by the researcher, these will be destroyed at the end of the study in July 2019. Any written information will be anonymised and stored in a locked filing cabinet in a secure location and destroyed by the end of the research in July 2019. Participants will be able to remove the data from the study after the focus group has been completed if they wish to. The transcripts from the focus-groups will be stored securely for a period of 10 years from collection.

What would happen if the researcher were concerned about yours or your client's safety?

If a researcher becomes concerned about your safety or that of your clients, they may need to contact their supervisor to follow up on this to ensure you and your client are safe.

What will happen to the results of this project?

The research team will analyse all the information gathered from the study which will then form part of a research project for the completion of a Doctorate in Clinical Psychology at the University of Exeter. If appropriate the findings may be published in academic journals and presented at conferences. We would also be happy to provide you with information about our findings if you wish to receive them.

What now?

We hope we have answered any questions you may have had about the research. If you would like to take part, please contact the researcher at the email below. There will be opportunities at the focus group to ask any further questions or please contact us prior to this if required.

Contact for further information

If you have any further questions, please feel free to contact us.

Claire Parker

Email: c.h.parker@exeter.ac.uk

STUDENT AND SUPERVISOR EXPERIENCES OF THE SPS

Researchers:

Dr Claire Parker (Trainee Clinical Psychologist)

Supervisors:

Dr Janet Smithson (Senior Lecturer in Psychology)

Dr Jenny Limond (Research Director, Consultant Clinical Psychologist)

This project has been reviewed and approved by University of Exeter

Dr Nick Moberly N.J.Moberly@exeter.ac.uk

Psychology Chair of Ethics, University of Exeter

Appendix H

Consent form (Student and Supervisor)

The validation of the SFP-SCS and therapists experiences of using it

Participant consent form

Please initial the box if you agree with the statement.

		Please initial
1.	I have read and understood the study information sheet (03.10.2018, Version 2).	
2.	I am satisfied with the information I have been given about the study and have had the opportunity to ask any questions.	
3.	I understand I am free to withdraw at any time, without giving a reason and this will not impact my clinical role.	
4.	I understand the data will be retained in secure storage.	
5.	I understand the findings from this project will be used for academic purposes; however my anonymity will be retained.	
6.	I understand the findings from this project may be used to inform service development, however my anonymity will be retained.	
7.	I give permission for my participation in the focus	

	group to be audio recorded.	
8.	I understand that discussions during the focus group may be quoted verbatim in publications. I give permission for my responses to be used in this manner.	
9.	I am happy to take part in the research.	

I agree to take part in this project.

.....	……..	.....
(Printed name of participant)	(Signature of participant)	(Date)
…….	……...	……
(Printed name of researcher)	(Signature of researcher)	(Date)

This project has been reviewed and approved by University of Exeter

Dr Nick Moberly N.J.Moberly@exeter.ac.uk

Psychology Chair of Ethics, University of Exeter

If you would like to receive feedback about the overall findings of the research (in approximately July 2019), please provide us with an email address:

Appendix I

Seven Steps in Good Quality Discourse Analysis (Potter & Wiggins, 2007)

Devising a research question: Guided by an interest in a particular form of interaction.

Gaining access and consent

Ethical and practical considerations for accessing the data.

Data collection and building a corpus

DA requires a thorough examination of a collection of similar instances

Transcription

Features of talk that are relevant are represented (emphasis, overlap, pauses, intonation etc.)

Coding

Iterative process of sifting through the data for instances of a phenomenon. Issues may emerge or disappear at this point.

Analysis

Focus on how discourse is constructed, constructs of different versions of events, is situated in interaction, and bound up with actions.

Application

Analysis and findings are linked to the context under study.

Appendix J

Conceptual Levels of Process within Discourse Analysis (adapted from Georgaca & Avdi, 2012).

Table 2.

Conceptual Levels of Process within Discourse Analysis (adapted from Georgaca & Avdi, 2012).

Level and name	Description
Level 1: Language as constructive	Examines how participants discuss and construct the 'object' of feedback and competence in a process of meaning making. At this stage cultural preconceptions of discourse around feedback and competence may be apparent and is important to explore how these may influence how language is constructed to do this.
Level 2: Language as functional	At this level, analysis examines the dynamics of interaction within the group, the ways in which participants' use of language serve particular functions in order to present their experiences. Understanding the discursive context, e.g. What came before? What followed? How does this impact participants understanding and experience within the group? Variability may be apparent through different contexts, e.g. how the feedback is received in light of each participant's identity or appraisal of the feedback? Does the group interaction facilitate a positive evaluation of receiving feedback?
Level 3: Positioning	Understanding how participants position themselves in the discussion will enable exploration of accountability, and raise questions around: Who speaks? Who do they address? How long do they speak for?
Level 4: Practices, institutions and power	This broader level enables a contextualisation of the questions addressed in the group and a further

	understanding around the role of specific discourses that are maintained or challenged within the group. Power and resistance between participants/researcher may be explored at this level.
Level 5: Subjectivity	This level is concerned with the effects of discourse on subjectivity and how discourses influence how individuals think, feel and experience themselves within the group discussion. It is at this level understanding how individuals position themselves in relation to the discourse of competence for example may be explored.

Appendix K

Dissemination statement

The findings from the study will be written up as part of the Doctorate of Clinical Psychology. It is anticipated both the systematic review and empirical paper will be written up for publication and submitted to a peer-reviewed journal, such as Journal of Family Therapy or The Clinical Supervisor. It is hoped there will be opportunities to present at local and national conferences relevant to the field for dissemination to wider academic and clinical audiences. The findings will also be peer-reviewed as part of the Doctorate in Clinical Psychology at the University of Exeter.

All participants will be given the opportunity to request the full findings of the research.

Appendix L

Copy of Instructions for Authors – Journal of Family Therapy

https://onlinelibrary.wiley.com/page/journal/14676427/homepage/forauthors.html

Author Guidelines

Manuscript submission

Papers submitted for publication should be original work not previously published in English and not currently submitted elsewhere for consideration. If accepted for publication, a paper cannot be published elsewhere in any language without the consent of both Editor and publisher. It is a condition of acceptance that the Association for Family Therapy and Systemic Practice automatically acquires the copyright throughout the world.

Manuscripts should be submitted to the following website: https://mc.manuscriptcentral.com/jft. Full submission instructions can be found on this website. By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Covering Letter

A cover letter should be submitted with your manuscript and must include a statement that the data has not been published, and is not under consideration for publication elsewhere. It will be presumed that all listed authors of a manuscript have agreed to the listing and have seen and approved the manuscript. The cover letter should include a statement outlining what is new, impact making and original about the paper and why it should be considered for publication.

Please also include a paragraph detailing the Authorship contribution detailing the Author(s) responsible each of the following:

- designing the work
- acquiring the data
- interpreting the data
- drafting the work/ revising the work critically for intellectual content

A statement from the authors agreeing to be held accountable for all aspects of the work and any questions relating to the accuracy or integrity of the work should also be included.

Manuscript Format

1. Manuscripts should allow for 'blind/anonymised' refereeing and **must not** contain author names or any identifiable data.
2. Manuscripts **must** be typed in double spacing throughout, including quotation, notes and references in the following order:

- Title Page: to contain the title of the paper, word count, suggested running head (short title for your paper), key words, author names, affiliations and contact details for the corresponding author.
- Abstract: on a separate sheet, the title to be repeated followed by a summary of not more than 150 words. The suggested running head should also be present. *For tips on optimizing your abstract for search engines please click here*.
- Practitioner Points: two to six bullet points of no more than 180 characters each (including spaces), up to a total of 480 characters.
- Organisation of the text: see copy of Journal for the format currently in use.
- Figures, tables, etc.: All figures and tables should be numbered with consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated. These will need to be uploaded separately. Please supply figures in the format in which they were created, if possible.

- References (in text): These should be indicated by the name and date e.g. 'Carr (2009)'. If more than two authors are listed, cite the reference as 'McHugh et al. (2010)'. Quotations should include page numbers. Websites should also be cited in this way, with a full reference appearing in the References section (see below). Please check all websites are live and the links are correct at time of submission.
- References: Should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details following the APA style of referencing.
    - **Articles**: Altschuler, J. (2015). Whose illness is it anyway? On facing illness as a couple. Journal of Family Therapy, 37(1), 119-133.
    - **Chapters**: Burnham, J. (2012). Developments in the Social GRRRAAACCEEESSS: visible-invisible and voiced-unvoiced. In I.B. Krause (Ed.), Culture and Reflexivity in Systemic Psychotherapy. Mutual Perspectives (pp 139-163). London: Karnac.
    - **Books**: Burck, C., & Daneil, G. (2010). Mirrors and Reflections. Process of Systemic Supervision. London: Karnac.
    - **Web pages** (no author or date identified): Counting the cost: caring for people with dementia on hospital wards. (n.d.) Retrieved from http://alzheimers.org.uk/site/scripts/ documents_info.php?documentID=1199. [Cite in text as (“Counting the costs”, n.d.)]

For further details, please see the APA Style website: (http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx)

3. The word limit, excluding abstract and practitioner points will vary depending on the type of paper you are submitting. Please refer to the ‘Advice to Authors’ section below.

4. Style: Whilst Journal style is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Your manuscript will be returned to you if you fail to conform to these requirements.

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Journal of Family Therapy readers particularly welcome papers which link theory and practice, and such papers are often enhanced by case material.

The Author takes responsibility for anonymising material in order to protect client confidentiality. All possible identifying information must be altered. Another way of protecting confidentiality is by presenting composite case material, made up of different aspects from a number of similar cases.

Do not identify any participants without consent or write about them in any way that identifies them to the public or other participants without consent.

Every paper that contains case material must be accompanied by:-

- A statement in the letter to the Editor from the Author(s) specifying whether the material presented is disguised/generic/composite; or
- A statement in the letter to the Editor that the Author has gained signed consent from patients/clients or teachers/students authorizing publication of the material. Please note that upon signing the Author Agreement the Author becomes liable for any third party information collated and takes complete responsibility for preparing the work and gaining the relevant permissions and consent.

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It is often helpful to Authors for whom English is a second language to choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found here.

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ADVICE TO AUTHORS

Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important both for the development of our chosen field and for the development of the individual practitioner. We intellectually sustain ourselves by creating a healthy and vibrant literature. Family therapy needs to develop authors and The *Journal of Family Therapy* wants to hear from you.

These are the types of papers that are regularly submitted to the *Journal of Family Therapy*:

(The word count for all these papers does not include tables and figures.)

Research Presentation (3,000-6,000 words)

A research paper should include:

- An introduction to the principal concepts and theoretical issues relevant to the study

- Previous work
- Description of methodology including participants
- Results/Findings
- Discussion of results, including implications for future research and practice

Systematic reviews (up to 6000 words).

Systematic reviews are welcomed. For systematic reviews and meta-analyses please ensure that you have used the PRISMA checklist and include a flowchart as part of your submission. Please complete and supply AMSTAR for systematic reviews which are narrative reviews not meta-analyses.

Suggested headings for systematic reviews are:

- background or context;
- objective;
- search strategy;
- inclusion criteria;
- data extraction and synthesis;
- main results; discussion and conclusions.

Please ensure that you include the standard points for practice.

You should provide the PROSPERO number in the methods section of the paper, or explain in your covering letter if you have not registered your review with PROSPERO.

Case Study (up to 2,000 words*)

*Longer papers may be considered at the discretion of the Editor if it is felt the manuscript fulfils the role of a full paper.

The *Journal of Family Therapy* welcomes case studies. A case study paper should include the following:

- Theoretical/Research Basis
- Introduction of the case including presenting issues

- Relevant background information
- Systemic case conceptualisation
- Self-reflexivity
- Description of intervention/ treatment
- Outcomes and follow up
- Implications/contributions to the field

For anonymised case studies informed consent to publish must be obtained from all participants in the treatment and/or all family members before submission.

CONSENT TO PUBLISH MUST ALWAYS BE OBTAINED FROM CLIENTS/FAMILIES BEFORE SUBMISSION

Theoretical Discussions or Controversial Theoretical Papers (4,000-6,000 words)

We welcome the submission of articles of this nature. A paper of this type would include:

- A brief general introduction
- A review of previous statements of the issues
- A definition of problems and solutions
- A development of an argument (Research based work which was undertaken for a thesis may be referenced)
- Relation of theory to practice
- Issues to be resolved

Often we will ask one of the reviewers to write a commentary on the paper to stimulate debate through the Journal pages.

Literature Review (3,000–5,000 words)

These are much sought after by the readership. Such a paper would have:

- A brief general introduction

- A description of the way in which the themes in the literature are organised by the author for review. This may include conceptual and definition problems.
- The review
- An overview of the review process including gaps in existing knowledge
- Future directions

Teaching and Learning (up to 2,000 words*)

*Longer papers may be considered at the discretion of the Editor if it is felt the manuscript fulfils the role of a full paper.

These should include:

- Practitioners Points – key ideas for trainers from paper
- Description of context – situation in which teaching event occurred, experience and constitution of participants and trainers, pre and post learning required for this session
- Aims of teaching event – aims and learning outcomes
- Theoretical Description which includes systemic theory / practice and education / learning/ pedagogical theory
- Description of event – pre reading, structure of session, length, didactic, experiential
- Feedback from participants – formal and informal
- Learning as a result of experience – trainers own evaluation, any suggested changes as a result of feedback or experience, suggestions for application in other settings

Additional Notes to Authors:

- JFT has an international readership, so spell out details that might be unfamiliar to the non UK field.
- JFT welcomes the linking of previous literature in a substantive, explanatory sense and therefore advises authors to reference other papers where possible.

PAPERS EXCEEDING THE SPECIFIED WORD LIMITS (including references) WILL BE RETURNED TO THE AUTHOR